
ARYNGOLOGICAL SOCIETY LONDON VOL. IX

PROCEEDINGS LARYNGOLOGICAL SOCIETY L

LIST OF EXCHANGES.

PERIODICALS:

The Journal of Laryngology, Rhinology, and Otology (London).
Archiv für Laryngologie (Berlin).
Revue Hebdomadaire de Laryngologie, etc. (Bordeaux).
Archivii Italiani di Laringologia (Naples).
Annales des Maladies de l'Oreille, du Larynx, etc. (Paris).
Bollettino delle Malattie dell' Orecchio, etc. (Florence).
The Laryngoscope (St. Louis, U.S.A.).
Monatsschrift für Ohrenheilkunde, etc.
Archivio Italiano di Otologia (Turin).
Archives Internationales de Laryngologie, Otologie, et Rhinologie (Paris).
La Parole (formerly Revue de Rhin., Otol., et Laryn.).

TRANSACTIONS OF THE FOLLOWING SOCIETIES:

British Laryngological, Rhinological, and Otological Association.
American Laryngological Association.
American Laryngological, Rhinological, and Otological Society.
Gesellschaft der Ungarischen Ohren- und Kehlkopfärzte.
New York Academy of Medicine, Section of Laryngology.
Wiener Laryngologische Gesellschaft.
Niederländische Gesellschaft für Hals-, Nasen-, und Ohrenheilkunde.
Laryngologische Gesellschaft zu Berlin.
Medical Society.
Brighton and Sussex Medico-Chirurgical Society.

Elected.

1899 Reid, St. George Caulfield, Thornton Heath, Croydon.
1895 *Ridley, W., F.R.C.S., Ellison place, Newcastle-on-Tyne.
1895 *Sandford, Arthur W., M.D., M.Ch., 13, St. Patrick's place, Cork, Ireland.
1898 Scatliff, J., M.D., 11, Charlotte street, Brighton.
1900 Skelding, H., M.B., B.C.Camb., St. Loyes, Bedford.
1896 Tomson, W. Bolton, M.D., Park street West, Luton, Beds.
1896 Turner, A. Logan, M.D., F.R.C.S.Ed., 20, Coates crescent, Edinburgh.
1895 Vincent, George Fourquemin, Hallaton, Leicestershire.
1897 Walker, Henry Secker, F.R.C.S., 45, Park square, Leeds.
1895 *Warner, Percy, Woodford.
1900 Westmacott, Frederic H., F.R.C.S., 8, St. John street, Manchester.
1893 **Williams, Patrick Watson**, M.D., 2, Lansdowne place, Victoria square, Clifton, Bristol. *C.*
1901 Yonge, E. S., M.D.Edin., 3, St. Peter's square, Manchester.

Elected.

1893 CHARSLEY, ROBERT STEPHEN, The Barn, Slough, Bucks.

1898 CLAREMONT, CLAUDE C., M.D., B.S , 57, Elm grove, Southsea.

1893 **DAVISON, JAMES**, M.D., M.R.C.P., Streate place, Bath road, Bournemouth.

1900 D'ESTERRE, J. N., 11, Seaside road, Eastbourne.

1895 DOWNIE, J. WALKER, M.B., 4, Woodside crescent, Glasgow

1898 FOXCROFT, F. W., M.B., 33, Paradise street, Birmingham.

1898 FRAZER, WM., Johannesberg, South Africa.

1902 GREEN, A. S., M.B., B.S., 9, West Parade, Lincoln.

1900 HAYES, GEORGE CONSTABLE, F.R.C.S., 22, Park Place, Leeds.

1897 HERDMAN, RONALD T., M.B., C.M., Gwélo, Rhodesia, South Africa.

O.M. HODGKINSON, ALEXANDER, M.B., 18, St. John street, Manchester. *V.-P.*

1894 HUNT, JOHN MIDDLEMASS, M.B., C.M., 55, Rodney street, Liverpool.

1898 HUTCHISON, A. J., M.B., 84, Lansdowne street, Brighton.

O.M. JOHNSTON, ROBERT MCKENZIE, M.D., F.R.C.S.Ed., 2, Drumsheugh gardens, Edinburgh. *C.*

1898 KELLY, A. BROWN, M.B., C.M., 26, Blythswood square Glasgow.

1990 KLEMPERER, FELIX, M.D., 42, Dorrotheen Strasse, Berlin.

1895 LINDSAY, DAVID MOORE, 373, Main street, Salt Lake City, Utah Territory, U.S.A.

1895 MACINTYRE, JOHN, M.B., C.M., 179, Bath street, Glasgow.

O.M. *MCBRIDE, PETER, M.D., F.R.C.S.Ed., 16, Chester street, Edinburgh. *V.-P.*

1898 **MARSH, F.**, F.R.C.S., 95, Cornwall street, Birmingham.

1893 MILLIGAN, WILLIAM, M.D., 28, St. John street, Manchester. *C.*

O.M. **NEWMAN, DAVID**, M.D., 18, Woodside place, Glasgow. *C.*

1990 O'KINEALY, CAPT., I.M.S., c/o Messrs. King and Co. Calcutta.

O.M. PATERSON, DONALD ROSE, M.D., M.R.C.P., 18, Windsor place, Cardiff.

1893 PERMEWAN, WILLIAM, M.D., F.R.C.S., 7, Rodney street, Liverpool.

Elected.

O.M. WALSHAM, WILLIAM JOHNSON, M.B., F.R.C.S., 77, Harley street, W. *T.*

1896 WHAIT, J. R., M.D., C.M., 124, Finchley road, Hampstead.

O.M. WILLCOCKS, FREDERICK, M.D., F.R.C.P., 14, Mandeville place, Manchester square, W.

1900 WILLEY, F. J. I., M.B., B.S.Dur., The Wych, Avenue road, Highgate.

O.M. *WILLS, WILLIAM ALFRED, M.D., M.R.C.P., 29, Lower Seymour street, W.

1897 *WINGRAVE, V. H. WYATT, M.D.Dur., 11, Devonshire street, W.

1897 YEARSLEY, P. MACLEOD, F.R.C.S., 33, Weymouth street, W.

COUNTRY.

The names of Country Members who have paid a "Compounding" Fee are printed in heavier type.

Elected.

O.M. BABER, EDWARD CRESSWELL, M.B., 46, Brunswick square, Brighton. *C. V.-P. P.*

1895 BARK, JOHN, F.R.C.S.Ed., M.R.C.P.I., 54, Rodney street, Liverpool.

1895 BARON, BARCLAY J., M.B., 16, Whiteladies road, Clifton. *C.*

1897 BEAN, C. E., F.R.C.S., 19, Lockyer street, Plymouth.

O.M. BENNETT, FREDERICK WILLIAM, M.D., 25, London road, Leicester. *C. V.-P.*

1895 BRADY, ANDREW JOHN, 3, Lyons terrace, Hyde park, Sydney, New South Wales.

1901 BRAINE-HARTNELL, J. C. R., Cotswold Sanatorium, Stroud, Glos.

O.M. BRONNER, ADOLPH, M.D., 33, Manor row, and 8, Mount Royd, Bradford. *C. V.-P.*

1894 BROWN, ALFRED, M.D., Sandycroft, Higher Broughton, Manchester.

1902 BROWNE, J. M., M.B., 27, Wellington road, Cork,

1898 BURT, ALBERT H., 34, Montpelier road, Brighton.

Elected.

1897 Ramsay, Herbert, F.R.C.S., 35A, Hertford street, Mayfair, W.

O.M. Rees, John Milsom, F.R.C.S.Ed., 53, Devonshire street, Portland place, W.

1898 Robinson, H. B., M.S., F.R.C.S., 1, Upper Wimpole street, W.

1894 *Roughton, Edmund, M.D., B.S., F.R.C.S., 38, Queen Anne street, W.

1893 Santi, Philip Robert William de, M.B., F.R.C.S., 15, Stratford place, Cavendish square, W.

1896 Schorstein, Gustave, M.B., F.R.C.P., 11, Portland place, W.

O.M. *Semon, Sir Felix, M.D., F.R.C.P., 39, Wimpole street, W. *P. V.-P. C.*

1894 Sharman, Henry, M.D., Sedgmore, Arkwright road, N.W.

1898 Snell, Sydney, M.D., Trinity road, Wandsworth Common.

1893 Spencer, Walter George, M.S., F.R.C.S., 35, Brook street, Grosvenor square, W. *C.*

1898 Spicer, Fredk., M.D., 17, Wimpole street, Cavendish square, W.

O.M. Spicer, Scanes, M.D., 28, Welbeck street, Cavendish square, W. *S. C. V.-P.*

1895 Stephen, G. Caldwell, M.D., 54, Evelyn gardens, South Kensington.

1898 Steward, Francis J., M.S., F.R.C.S., 24, St. Thomas's street, S.E.

O.M. Stewart, William Robert Henry, F.R.C.S.Ed., 42, Devonshire street, Portland place, W. *S. C. V.-P. T.*

O.M. *Symonds, Charters James, M.S., F.R.C.S., 58, Portland place, W. *C. V.-P.*

1894 *Thomson, StClair, M.D., 28, Queen Anne street, Cavendish square, W. *S. C. L.*

1896 *Thorne, Atwood, M.B., 10, Nottingham place, W.

1893 Tilley, Herbert, M.D., B.S., F.R.C.S., 89, Harley street, W. *S. C.*

1900 Tod, Hunter F., M.B., London Hospital, E.

1990 Vinrace, Dennis, 24, Alexander square, S.W.

1893 Waggett, Ernest Blechynden, M.B., 45, Upper Brook street, Grosvenor square, W. *S. C.*

Elected.

1894 Hill-Wilson, A. E., 217, Goldhawk road, W.
O.M. Holmes, W. Gordon, M.D., 27, New Cavendish street, W.
1894 Horne, Walter Jobson, M.B., 4, Clement's Inn, W.C.
O.M. Hovell, T. Mark, F.R.C.S.Ed., 105, Harley street, W.
1901 Hudson, A. A., M.D.Ed., 3, Ellerdale road, N.W.
1895 Jakins, Percy, M.D., 120, Harley street, W.
1894 Jessop, Edward, 81, Fitzjohn's avenue, Hampstead, N.W.
1897 *Kelson, William H., M.D., B.S., F.R.C.S., 16, Old Burlington street, W.
O.M. Kidd, Percy, M.D., F.R.C.P., 60, Brook street, Grosvenor square, W. *C.*
1895 *Lack, Lambert Harry, M.D., F.R.C.S., 48, Harley street, W. *S. C.*
1893 Lake, Richard, F.R.C.S., 19, Harley street, W. *C.*
O.M. *Law, Edward, M.D., 8, Wimpole street, W. *C. V.-P.*
O.M. Lawrence, Laurie Asher, F.R.C.S., 9, Upper Wimpole street.
1899 Lazarus, A. B., M.B., C.M.Edin., 77, Wimpole street, W.
O.M. Macdonald, Greville, M.D., 85, Harley street. *C. V.-P.*
1895 *Macgeagh, T. E. Foster, M.D., 23, New Cavendish street, W.
1894 Mackenzie, Hector William Gavin, M.D., F.R.C.P., 34, Upper Brook street, W.
1894 Mackern, George, M.D., c/o Dr. P. Kidd, 60, Brook street.
1900 Mackintosh ,J. S., St. Ives, Platts lane, Hampstead.
1900 Nourse, Chichele, F.R.C.S.Ed., Abchurch House, Sherborne Lane, King William street, E.C.
1897 Paget, Stephen, F.R.C.S., 70, Harley street, W.
O.M. Parker, C. A., F.R.C.S.Ed., 141, Harley street. *S.*
1893 *Pegler, Louis Hemington, M.D., 2, Henrietta street, W.
1895 Perkins, J. J., M.B., 41, Wimpole street, W.
O.M. Pollard, Bilton, F.R.C.S., 24, Harley street, W.
1894 Potter, Edward Furniss, M.D., 49, Queen Anne street, W.
1894 *Poulter, Reginald, 4, Gordon mansions, Francis street, Gordon square, W.C.
1899 Powell, H. Fitzgerald, M.D., F.R.C.S.Ed., 7, Connaught street, Hyde park, W.

Elected.

O.M. *Bond, James William, M.D., 26, Harley street, W. *C. V.-P.*

O.M. Bowlby, Anthony Alfred, C.M.G., F.R.C.S., 24, Manchester square, W. *C. V.-P.*

1900 Budd Budd, E. J., 73, South side, Clapham Common.

O.M. Butlin, Henry Trentham, F.R.C.S., 82, Harley street, W. *T. P.*

1900 Carson, H. W., F.R.C.S., Craigholm, Upper Clapton, N.E.

1895 Cathcart, George C., M.B., C.M., 35, Harley street, Cavendish square, W.

1895 *Cheatle, Arthur H., F.R.C.S., 117, Harley street, W.

1893 Colbeck, Edmund Henry, M.D., M.R.C.P., 55, Upper Berkeley street

1899 Collier, M P. Mayo, F.R.C.S., 133, Harley street, W.

1894 *Cripps, Charles Cooper, M.D., 187, Camberwell grove, S.E.

O.M. *Crisp, Ernest Henry, 43, Fenchurch street, E.C.

1899 Davis, Henry J., M.B., M.R.C.P., 9, Norfolk crescent, Hyde park, W.

1898 Dixon, F. J., M.B., B.C., Dulwich Village, S.E.

1893 *Donelan, James, M.B., 6, Manchester square, W.

1896 Dorman, Marcus R. P., M.B., B.C., 9, Norfolk crescent, Hyde park, W.

1894 Drysdale, John Hannah, M.B., M.R.C.P., 25, Welbeck street, W.

1898 Fergusson, Arnold, F.R.C.S.Ed., 34, Canfield gardens, Hampstead.

1901 Glegg, Wilfred, M.D., M.R.C P.Ed., Throat Hospital, Golden square.

1896 Glover, Lewis Gladstone, M.D , 17, Belsize park, Hampstead, N.W.

O.M. *Grant, J. Dundas, M.A., M.D., F.R.C.S., 18, Cavendish square, W. *C. L. V.-P.*

O.M. *Hall, Francis de Havilland, M.D., F.R.C.P., 47, Wimpole street, W. *L. V.-P. P. C.*

1895 Hamilton, Bruce, 9, Frognal, West Hampstead.

1893 Harvey, Frederick George, F.R.C.S.Ed., 4, Cavendish place, Cavendish square, W.

1899 *Heath, Charles, F.R.C.S., 3, Cavendish place, W.

O.M. *Hill, G. William, M.D., 26, Weymouth street, W. *S. C.*

Laryngological Society of London.

LIST OF MEMBERS,

JANUARY, 1902.

INDEX TO ABBREVIATIONS.

Indicating Past or Present Officers of the Society.

(*P.*) PRESIDENT. (*L.*) LIBRARIAN.
(*V.-P.*) VICE-PRESIDENT. (*S.*) SECRETARY.
(*T.*) TREASURER. (*C.*) COUNCILLOR.
(O.M.) ORIGINAL MEMBER.

LONDON.

Members who pay their Annual Subscription through a Banker's Order (to be obtained from the Treasurer) have an asterisk prefixed to their names.

Elected.

1899 ABERCROMBIE, PETER, M.D.Glasg., 56, Harley street, W.

1899 AGAR, MORLEY, 76, Wimpole street, W.

1893 *AIKIN, WILLIAM ARTHUR, M.D., 14, Thurloe square, S.W.

1893 AYRES, CHARLES JAMES, M.D., 55A, Welbeck street, Cavendish square, W.

O.M. BALL, JAMES BARRY, M.D., 12, Upper Wimpole street, W. *C.*

1896 BATEMAN, F. A. N., 4, Charles street, St. James's, S.W.

O.M. BEALE, EDWIN CLIFFORD, M.B., F.R.C.P., 23, Upper Berkeley street, W. *S. L. T. V.-P.*

HONORARY MEMBERS.

FRAENKEL, Professor B., 4, Belle Vue Strasse, Berlin, N.W.
GARCIA, MANUEL, Mon Abri, Shoot-up hill, Cricklewood.
LEFFERTS, G. M., 212 Madison Avenue, New York, U.S.A.
MASSEI, Professor, 4, Piazza Municipio, Naples, Italy.
MOURE, E. J., 25bis, Cours du Jardin Publique, Bordeaux.
SCHMIDT, Professor MORITZ, Frankfort-on-the-Main, Germany.
v. SCHRÖTTER, Professor, 3, Marianengasse I, Vienna.
SOLIS-COHEN, J., 1431, Walnut street, Philadelphia, U.S.A.
WALKER, THOMAS J., M.D., Peterborough.

DECEASED HONORARY MEMBERS.

JOHNSON, SIR GEORGE .	. Died 1896.
MEYER, HANS WILHELM, M.D.	. Died 1895.
STÖRK, Professor . . .	. Died 1899.

LARYNGOLOGICAL SOCIETY

OF

LONDON.

LIST OF MEMBERS.

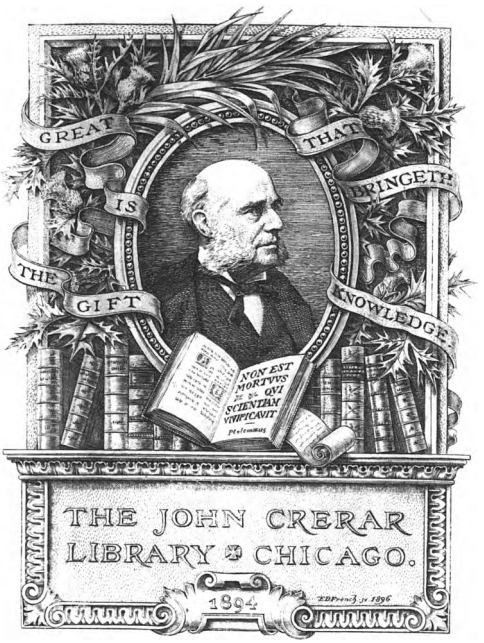
1902.

LONDON:
PRINTED BY ADLARD AND SON,
BARTHOLOMEW CLOSE, E.C.

1902.


ARYNGOLOGICAL SOCIETY LONDON VOL. IX.

PROCEEDINGS LARYNGOLOGICAL SOCIETY



PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY

OF

LONDON.

VOL. IX.

1901—1902.

WITH

LIST OF OFFICERS, MEMBERS, ETC.

LONDON:
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BARTHOLOMEW CLOSE, E.C.

1902.

OFFICERS AND COUNCIL

OF THE

Laryngological Society of London

ELECTED AT

THE ANNUAL GENERAL MEETING,

JANUARY 10TH, 1902.

President.

E. CRESSWELL BABER, M.B.

Vice-Presidents.

E. CLIFFORD BEALE, M.B., F.R.C.P. F. W. BENNETT, M.D.
DUNDAS GRANT, M.D.

Treasurer.

WILLIAM STEWART, F.R.C.S. (Edin.).

Librarian.

STCLAIR THOMSON, M.D., F.R.C.S.

Secretaries.

CHARLES A. PARKER, F.R.C.S. (Ed.). JAMES DONELAN, M.B.

Council.

F. DE HAVILLAND HALL, M.D., F.R.C.P. RICHARD LAKE, F.R.C.S.
SIR FELIX SEMON, M.D., F.R.C.P. ERNEST WAGGETT, M.B.
H. LAMBERT LACK, M.D., F.R.C.S. J. BARCLAY BARON, M.B.

PRESIDENTS OF THE SOCIETY.

(*From its Foundation.*)

ELECTED	
1893	Sir George Johnson, M.D., F.R.S.
1894-6	Sir Felix Semon, M.D., F.R.C.P.
1897-8	H. Trentham Butlin, F.R.C.S.
1899-1900	F. de Havilland Hall, M.D., F.R.C.P.
1901-2	E. Cresswell Baber, M.B.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SIXTY-EIGHTH ORDINARY MEETING, *November 1st*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B.,
CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—46 members and 2 visitors.

The minutes of the preceding meeting were read and confirmed.

The following report of the Morbid Growths Committee was read:

Mr. Lake's specimen of laryngeal growth (Slide No. 20), see 'Proceedings,' March, 1900, page 71. The section presented shows the structure of a glandular carcinoma.

Dr. Potter's case of growth in the region of the left tonsil (Slide No. 21), see 'Proceedings,' May, 1900, page 114. The section submitted for examination shows the structure of a large round-celled sarcoma.

Mr. Mark Hovell's case of laryngeal growth (Slides 22, 23, and 24), see 'Proceedings,' May, 1901, page 120. Fresh sections were cut by Dr. Horne from fragments removed in 1886 (Slides

22 and 23) and 1887 (Slide 24). The Committee are of opinion that the histological structure of the specimens submitted to them is that of a benign papilloma.

Dr. Lambert Lack's case of laryngeal tumour (Slide 25), see 'Proceedings,' May, 1901, page 128. The Committee consider the case to be one of mixed cell sarcoma.

The following cases, specimens, and drawings were shown:

Case of Tertiary Syphilitic Laryngeal Stenosis treated by Laryngofissure without Tracheotomy (Re-exhibited).

Shown by Mr. W. G. Spencer. The patient, a potter, was operated upon in March, 1899, for severe dyspnœa, not relieved by large doses of iodide of potassium and mercury.

Tough, irregular masses of inflammatory sclerosed tissue covered the ventricular bands and partly the vocal cords, which, however, moved fairly, and the cartilaginous framework was not involved. Much of the obstructing tissue was excised, including part of the right vocal cord. The patient has remained well and at work, breathing freely as well by night as by day. He has a hoarse but thoroughly audible voice. The inflammatory hypertrophy of the cord on one side now crosses the middle line so as to meet the remaining portion of the excised cord. When exhibited, soon after recovery, the opinion of the meeting was strongly in favour of tracheotomy for such cases, and it was thought that this patient would soon require it (see vol. vii, page 62).

The case shows that tracheotomy is not always best, but that in selected cases, especially where the cartilages are not involved, success is to be obtained by thyrotomy and excision.

The President congratulated Mr. Spencer on the successful result obtained, for there was no contraction of the wound in this case. The man had a very fair amount of voice and was certainly more comfortable than he would have been if he had had tracheotomy performed.

Mr. P. de Santi said the case he had intended to show was of the same nature as Mr. Spencer's but was one where tracheotomy had been performed, and the man's life was a burden to him. He was unable to do any work, and ready to have any operation whatever

done so long as he could get rid of the inconvenience caused by the tracheotomy tube. If tracheotomy could have been avoided with a result equally as good as in Mr. Spencer's case, it would have been a great advantage to the patient.

Dr. HERBERT TILLEY said that the case referred to by Mr. de Santi had recently been operated on by the speaker at the Golden Square Hospital. The patient was very anxious to dispense with the tube, and laryngoscopic appearances seemed to indicate that if the left ventricular band and vocal cord were removed sufficient room would be provided for natural respiration. Thyrotomy was performed, but it was found that the cicatricial tissue extended below the larynx and was particularly marked in the cricoid region. Hence little good could be expected from removal of the left vocal cord and ventricular band.

Mr. W. G. SPENCER said the Germans had been trying grafting skin and turning the flap in as a means of checking the stenosis. Perhaps Dr. Tilley and other members would try this flap method. It had apparently been attended with some success, especially as regards getting rid of the tracheotomy tube.

An account of some cases in which this operation had been performed would be found in the Centralblatt für Chirurgie.

A SERIES OF SPECIMENS, PHOTOGRAPHS, AND DRAWINGS, ILLUSTRATING THE INFLAMMATORY DISEASES OF THE NASAL FOSSÆ AND ACCESSORY CAVITIES.

Shown by Mr. F. WESTMACOTT. One dry preparation showed a marked frontal projection of the anterior ethmoidal cell. Another a very large sphenoidal cavity coming far forwards and with very thin walls.

Several photographs and drawings taken from specimens in Zuckerkandel's Museum in Vienna presented some abnormalities in size of Highmore's cavity and of the ethmoidal and frontal sinuses, and also hypertrophies of mucous membrane in the nasal fossæ.

TWO MOLAR TEETH SHOWING HEALTHY CROWNS, BUT EVIDENCES OF CARIES IN THE PALATAL ROOT—IN EACH CASE THERE EXISTED AN EMPYEMA OF THE CORRESPONDING ANTRUM.

Shown by Dr. HERBERT TILLEY, who pointed out that although the crown of a tooth might appear healthy it did not prove

that the roots were not diseased and the cause of antral suppuration; hence in a given case of antral suppuration the healthy aspect of the corresponding molar teeth should not at once lead to the inference that such an empyema was due to intra-nasal causes. If the patient experienced pain or discomfort in a tooth, which was coincident with an increase of the antral symptoms, such a tooth should be regarded with suspicion, no matter how healthy its crown might appear.

In one of the cases referred to, the abscess around the palatal root had free access to the antrum; in the second, a small abscess was situated in the recess at the root of the fangs.

Mr. PARKER asked Dr. Tilley whether there were any signs of pyorrhœa alveolaris, because otherwise he did not see how caries and suppuration could occur at the roots of the teeth, unless it was secondary to the sinus disease. The only conditions which could account for it would be either ordinary caries proceeding from without inwards, or else pyorrhœa, and if there was no pyorrhœa in these cases he should look upon the caries of the fangs as being secondary to, rather than the cause of, the sinus suppuration.

Mr. WAGGETT wished to say in contradistinction to the previous speaker that Tomes, in his 'Dental Surgery' (Ed. iv, page 389), points out that one may meet with necrosis of the pulp without any external wound of the tooth whatever, an abscess forming from pus escaping through the apex of the fang.

Mr. NOURSE was of opinion that there was a small area of caries on the crown of one of the teeth.

Mr. WESTMACOTT said that this question of an apparently sound tooth with an abscess at the root had recently come under his consideration in the case of a doctor, who had, when he first saw him, antral suppuration on the right side. Apparently the set of teeth on that side was perfect. He noticed a symptom which to him was new, and he had not found any confirmation of it elsewhere. By trans-illumination with a strong lamp in the right side of the mouth, the first molar was opaque, the other teeth being perfectly transparent. From the experience of a previous case he came to the conclusion that the first molar was "dead," and advised its removal. An abscess was found at the apex of the palatine root leading into the antrum, and which was apparently the cause of the empyema. The same thing had, within the past month, been again brought to his notice in the case of a gentleman who applied to him with marked irritation at the front of the hard palate. Nothing could be found to account for this until, by means of trans-illumination, it was discovered that the right central incisor was opaque. On removing it, an abscess was found at the root of the tooth. After extraction all the symptoms disappeared.

Dr. StClair Thomson said he had just been reading an old book—Spencer Watson's book on 'Diseases of the Nose,' and found the following on page 161: "It may happen that the teeth are all apparently sound, and yet one of them may be the cause of the purulent collection within the antrum in consequence of the death of the fang, the symptoms of which are not by any means easily detected. The skilful dentist, however, is sometimes able to get information on this point by striking the crowns of the teeth in succession with a metallic rod until one of them is found to be more sensitive than the rest, and he then proceeds to test the condition of the pulp cavity of the suspected tooth. . . . ." Dr. Thomson was sorry that they could not consult with dentists on this subject, because he had had cases in which the patients had insisted on having certain teeth extracted, which were found to have diseased fangs when there was nothing to be detected in the crown. He could not say whether in these cases the tooth was the cause, or whether it was secondarily infected. He believed he had read that the Röntgen rays were being used for the purpose of detecting diseased roots of teeth. He did not know if any member had come across this in the literature on the subject, or if anyone skilled in dentistry could tell them about the procedure.

Case of Laryngeal Syphilis with Fixation of Left Vocal Cord.

Shown by Dr. Donelan. The patient, a man æt. 52, had contracted syphilis sixteen years previously. Three weeks ago there was a large foul ulcer occupying the left side of the larynx and involving the left arytenoid, vocal cord, ary-epiglottic ligament, and extending past the middle line on the posterior surface of the epiglottis with several unhealthy granulations. There was complete fixation of the left vocal cord. There had been remarkable improvement under antisyphilitic treatment so far, but in view of the unilateral character of the affection, and the existing appearances, he desired the opinion of members as to whether there was not malignant disease as well.

Mr. Spencer thought the antisyphilitic treatment might be continued for some time, as it looked likely to be successful.

MAN, ÆT. 33, SHOWN AT THE MEETING IN APRIL LAST (vide '*Proc.*,' p. 104) WITH CHRONIC LARYNGITIS AND AN ULCER ON ONE VOCAL CORD. NOW SEEN TO PRESENT MARKED LUPUS INFILTRATION AND ULCERATION OF THE EPIGLOTTIS.

Shown by Dr. STCLAIR THOMSON. This patient has now complained of hoarseness and a constant desire to clear his throat for about a year. When shown to the Society six months ago the author raised the question as to the ulcer on one cord and the general thickening and congestion of both cords being due to tubercle, but he abandoned it in the absence of any confirmatory signs, and also because some purulent rhinitis was thought to be a sufficient explanation of the condition. Several members expressed their opinion that it was only a case of simple laryngitis, and some even thought that the man's hoarseness was to a great extent functional.

On June 1st last it was noticed that no ulcer was visible on the cords, which were simply thickened, catarrhal, with granulations along their attached border. For the first time the epiglottis was then noticed to be red, velvety, and infiltrated with slight vertical fissures (? commencing ulceration) on its laryngeal surface. He did not come under observation again until October 20th, when the epiglottis presented the condition which may now be observed. It has lost much of its contour, being thickened, red, congested-looking, and with marked loss of substance and tubercular infiltration of the floor of the ulcers. There is no marked dysphagia. The voice remains hoarse and painful.

The PRESIDENT asked whether there were any symptoms or history of syphilis in this case, and also whether tubercle bacilli had been found.

Dr. JOBSON HORNE did not know why it should be regarded as a case of lupus. To him, it seemed a fairly straightforward case of tuberculous disease.

Dr. STCLAIR THOMSON said, in reply to the President, that there was no distinct history of syphilis in this case. He had been put on ten grains of iodide of potassium, but it had made him rather worse; this, of course, tended to confirm the suspicion of tuberculosis. There was a great clinical difference between tuberculosis and lupus in the larynx,

a point which he had previously raised before the Society. He thought this distinction assumed its greatest importance in regard to the question of treatment, because if this was a case of lupus of the epiglottis, it was a form of disease most amenable to treatment; but if it was a tuberculous epiglottis, it was one of the most malignant of laryngeal affections.

Case of ? Congenital Fenestration of the Anterior Pillars of the Fauces.

Shown by Dr. E. Waggett. The case was a well-marked example, occurring in a woman æt. 43, of the condition of which several instances had been exhibited at meetings during the past year. History of ulceration was completely wanting, but the patient had scarlet fever at an early age.

Dr. Clifford Beale said that considerable interest was attached to this case, in association with cases previously shown to the Society, because the question was raised whether such fenestration could be due to scarlet fever. It struck him at the time that there was not very much evidence generally forthcoming to show that scarlet fever was followed by such fenestration. Since then he had looked up the literature of the subject and seen what the authorities had to say in this matter. The result was that he found several recent editions of present text-books had quoted from one another, and that finally the quotations came from one source—a paper by Goodall, in 1894, recording a short series of cases where there was definite fenestration after scarlet fever. No one else appeared to have brought forward such cases. He had the personal evidence of physicians at the fever hospitals to the effect that it is almost outside their experience to meet with palatal fenestration after scarlet fever. One physician had told him that he had come across one case where perforation had followed, but otherwise he had never seen it. That is to say, although ulcers of the soft palate follow scarlatina—they are, indeed, fairly common—they do not usually end in fenestration, but in recovery.

Dr. Donelan referred to the recent literature of this subject, particularly to the cases of Monro, of Glasgow, and Koenig, of Paris, as showing that perforations of this kind were liable to be due to so many varieties of infection that the question whether a given case was congenital or otherwise was attended by increasing difficulty. In Monro's case, which appeared in the October number of the 'Glasgow Medical Journal,' the bacteriological evidence appeared to show clearly that the erosive action was due to the pneumococcus.

Dr. FitzGerald Powell thought that there was very little doubt that this was a case of perforation resulting from ulceration. The openings, it would be observed, were certainly surrounded by

bands of white cicatricial tissue, which showed that there had been ulceration, whether scarlatinal or not in origin he could not say.

Some time ago he showed a case of malformation of the fauces, which he thought was due to developmental causes, and which looked much more like it than the present case, but the general opinion was, on that occasion, that it was due to scarlatinal ulceration.

He thought Mr. Waggett had, on previous occasions, shown cases which confirmed this opinion.

Mr. WAGGETT, in answer, agreed with Dr. Powell in thinking that scarring was present, and that the condition was probably, in this case, due to ulceration.

A SERIES OF LIVING CULTURES OF THOSE BACILLI WHICH SIMULATE BACILLUS TUBERCULOSIS BY THEIR STAINING REACTION.

Shown by Mr. ST. GEORGE REID. Each culture was supplemented by a microscopical drawing of the organism. They included besides Koch's bacillus tuberculosis, the bacillus tuberculosis of fish, *Dubard,* by inoculation; and the following organisms isolated by Moeller: the bacillus tuberculosis from the blindworm, a bacillus from manure, the Timothy grass bacillus, and grass bacillus I and II—five different bacilli isolated from butter by Maria Tobler; those isolated from butter by Rabinowitsch and Grassberger; Korn's bacilli Nos. I and II, also from butter, and Marpmann acid fast bacillus from the urine.

Mr. St. George Reid explained that all the microscopical preparations from these cultures had stood a prolonged soaking in 15 per cent. acid solution, and in acid-alcohol without yielding up the carbol-fuchsin stain; but that the cultures themselves showed how extremely they differed in their manner of growth from that of Koch's bacillus. Under the microscope, while some organisms simulated exactly bacillus tuberculosis, others showed a very distinct variation from that bacillus, as shown when it was obtained from fairly recent cultures.

CASE OF GROWTH (PROBABLY PAPILLOMA) ON THE LEFT VOCAL CORD IN A MAN ÆT. 32, A PORTER BY OCCUPATION.

Shown by Dr. FITZGERALD POWELL. The patient stated that in February this year he began to suffer from hoarseness and difficulty in singing, which had gradually got worse. There had

been no pain or dyspnœa. On examination, an irregular sessile growth is seen arising from the anterior three-fourths of the left vocal cord. It is nearly white in colour and shows slight papillary projections on the surface. The growth is most probably a papilloma, containing some fibrous tissue. It is interesting to note in these cases of benign neoplasms of the larynx arising from the cords, even when of considerable size, the slight amount of interference with the breathing in adults.

Dr. Clifford Beale asked whether a papilloma of such a very white colour was not very uncommon? He suggested that such an excellent case should be recorded by means of a coloured drawing.

Dr. Law wished to point out that the late Dr. Whistler showed a case to the Society some years ago in which the growth was even much whiter than the present one.

The President remarked on the whiteness of the growth.

Case of Epithelioma of the Epiglottis in a Man æt. 58.

Shown by Dr. Dundas Grant.

Mr. Butlin said he believed Dr. Grant did not so much raise the question of diagnosis as that of operative interference, and from that point of view he would not regard the case as a favourable one. He had never operated on a case in a similar condition to this, and he was doubtful as to which was the best way of exposing the growth. Seeing that the man had a gland on the right side and that the gland was movable, he thought it would be best to cut down on it and make an extensive incision on the right side, getting to the base of the tongue and epiglottis, and then to make a thorough examination. At Dr. Grant's request he had put his finger down onto the back of the tongue as far as the epiglottis, which was very hard. The base of the tongue was also indurated, but not to the extent he had anticipated, taking into consideration the visible thickening. There seemed to be little infiltration. Those cases that one saw, not very uncommonly, of malignant disease in front of the epiglottis spreading along the base of the tongue and backwards into the epiglottis, he had never yet ventured to attack by operation, the disease was so deep-seated and extensive; but he had often thought that he would expose the growth from the outside when a suitable case came before him, although he doubted whether it would be successful. Here he would expose the growth from the side and remove the glands at the same time, if he were going to operate from the outside.

Dr. Lambert Lack agreed that the case was quite unsuitable for

operation. Not only the larynx but so much of the adjacent parts of the anterior wall of the pharynx and tongue would have to be removed that it would be quite impossible to close the wound. In early cases of epithelioma spreading from the tongue to the epiglottis, it was sometimes possible to remove the disease without removing the larynx, and in these cases he had seen very good results.

Case of Nasal Stenosis occurring in a Man æt. 43, in which the Symptoms seemed to be chiefly Subjective.

Shown by Dr. Dundas Grant.

The President said it seemed to him that the patient had a good deal of objective inspiratory obstruction; in addition to the very irregular septum, the collapse of the alæ on inspiration made it difficult for the man to inspire.

Dr. Pegler noticed some constriction of the folds of the limen vestibuli which might contribute to the general stenosis. He hoped Dr. Grant would show the case again after the objective conditions had been treated.

Dr. FitzGerald Powell thought the symptoms were chiefly objective; there was also some superficial ulceration about the anterior nares which rather suggested a specific taint, and he would suggest putting the man on anti-specific treatment.

Case of ? Tubercular Disease of the Epiglottis.

Shown by Mr. H. M. Ramsay. The patient, a girl æt. 19, an envelope sorter, complains of cough and hoarseness. She states that she was quite well till eight months ago, when she noticed an alteration in her voice, and began to be troubled by a cough. On examination, she has extensive thickening and lumpiness of the epiglottis and ary-epiglottidean folds. It is difficult to see the cords, but they seem to be very little affected and to move freely. The patient has no pain. The chest is normal, and no tubercle bacilli have been found in the sputum. The case is shown with a view to diagnosis.

Dr. StClair Thomson thought this case was, clinically, a very typical example of lupus. There was the greatest difference between that and tuberculosis of the same extent in the larynx. If this girl had no mischief in her lungs, it was one of the most favourable cases

for local treatment, and it was quite possible to make a cure of it. He had recently seen such a case, in which the disease, apparently quite as extensive as in this girl, was completely arrested by the use of the galvano-cautery in one of his colleague's hands. He mentioned this because he had heard in the Society many expressions of opinion against the use of the galvano-cautery in the larynx. The case he referred to was one of extensive lupus, not only of the epiglottis, but also of the ary-epiglottic folds, and treatment with the cautery resulted in complete arrest.

Mr. BUTLIN said that with regard to the use of the galvano-cautery in the larynx, a well-marked case of lupus was once handed over to him. The patient was in the hospital. He applied the cautery very freely indeed, and in the end succeeded in getting the disease cured. But he was bound to admit that on one occasion the patient nearly died, and certainly would have died had he not instantly performed tracheotomy in the ward. Anybody who was going to apply the cautery in the larynx in the case of lupus unaided should be prepared for such a contingency.

CASE OF LARYNGEAL SWELLING.

Shown by Dr. BOND. The patient, a boy æt. 14, has had a peculiar voice since infancy. On the left side the cord is masked by a swelling, especially in front and low down, red in colour, slightly granular and moving with phonation. Occasionally a small portion of base of cord can be seen. The boy is unable to obtain work because of his peculiar voice. Suggestions as to treatment of the condition will be welcomed.

Dr. LAW would suggest as a possible, but very improbable, explanation of the condition, the impaction of a foreign body. He remembered when he was House Surgeon at Golden Square a patient coming to the hospital for four or five months presenting a very similar appearance in the larynx to this patient. He heard a year or two afterwards that a piece of rabbit bone was one day extracted which had not been visible during the previous year's observation.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SIXTY-NINTH ORDINARY MEETING, *December 6th*, 1901.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B.,
CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—35 members and 5 visitors.

The minutes of the preceding meeting were read and confirmed.

The following gentleman was nominated for election at the next meeting of the Society:

Arthur Stanley Green, M.B., B.S.Lond., 9, West Parade, Lincoln.

The following cases and specimens were shown:

PERFORATION OF LEFT FAUCIAL PILLAR.

Shown by Dr. FURNISS POTTER. This case was exhibited chiefly because it presented a considerable contrast to the case shown by Mr. Waggett at the last meeting of the Society, and

also because of Dr. Clifford Beale's remarks on that occasion, who stated that from inquiry he had learned that perforation as the result of scarlet fever was almost outside the experience of physicians at the fever hospitals.

The patient, a single woman æt. 24 years, stated that she had scarlet fever when she was four years of age, at which time she had "a very bad throat and mouth." No history of syphilis was obtainable. On examination a slit-like opening about three quarters of an inch long was seen in the left anterior faucial pillar, through which a probe could easily be passed. In the right posterior pillar there was the appearance as of a perforation, but a probe could not be passed through. There was considerable cicatricial tissue in the pharynx, and the right posterior pillar was partially adherent to the pharyngeal wall. The angles of the mouth were scarred. There were no signs of tonsils. As a result of the scarring there was considerable deformity and interference with distinct articulation, the patient speaking in a manner somewhat resembling that of a case of cleft palate.

Dr. Clifford Beale said that on looking at the case one could not help having rather a doubt as to its causation. There were scars on the edges of the lips and elsewhere in the mouth, which were, in his opinion, most probably due to infantile syphilis. He thought it hardly fair to label the case as being definitely and entirely due to scarlet fever. If scarlatinal ulceration was a common cause of perforation more cases would have been noted, since scarlatinal patients were always kept under observation for some weeks after the cessation of the fever.

Sir Felix Semon did not quite know for what purpose the case had been shown. Was it merely to show the occurrence of perforations in the palate, or was it brought forward as a counterproof against the possibility of a *congenital* formation of such clefts in the palate? He thought the case was an excellent illustration of the fact that faucial webbing might be developmentally explained. He could not think of a better illustration showing the difference between a congenital defect and one of ulcerative agency, for in the congenital cases there was absolutely no trace of *cicatricial* tissue at the edges of the clefts, whereas in this case the cicatricial tissue was most marked.

Dr. F. de Havilland Hall suggested that possibly scarlet fever might have had something to do with the condition by depressing the patient's vitality, and allowing the poison of hereditary syphilis to act.

Dr. Furniss Potter said, in reply, that with regard to Dr. Clifford Beale's remarks as to syphilis acting as a cause, he had carefully

Process reproduction of a photograph of a larynx removed, July 18th, 1898, from a woman aged 23, a subject of Hodgkin's disease.

The larynx has been opened to show an ulcer on the posterior part of the left vocal cord; the adjacent lymphatic glands are considerably enlarged. No evidence of tuberculosis was found in the lungs.

To illustrate Dr. Jobson Horne's communication on a "Path of Infection in Hodgkin's Disease."

To face page 15, Vol. IX. *Adlard & Son, Imp.*

questioned the girl, but could not elicit any history leading him to suppose that she or her family had been affected by syphilis. The patient stated that she suffered at the time of having scarlet fever from very severe ulceration of the throat and mouth, the ulceration, in fact, extending to the mucous membrane inside the cheeks, and to the lips. This would, he supposed, account for the scars at the angles of the mouth.

With regard to Sir Felix Semon's question, he showed the case because he thought it was in sharp contrast to the one shown by Mr. Waggett at the November meeting, and also because it would be of interest after Dr. Clifford Beale's remarks on that case in November.

Macroscopic and Microscopic Specimens of the Larynx from Cases of Lymphadenoma, Lympho-sarcoma, Tuberculous Lymphadenitis, etc.

Shown by Dr. Jobson Horne. Dr. Jobson Horne exhibited and demonstrated these preparations, and said that upon them he had based his opinion that the diseases generally grouped under the name of Hodgkin's disease were due to infection, and that one manner of entry of the infecting agent was through ulceration in the larynx. An account of the work he had done on this subject would be found in the 'Journal of Laryngology' for December, 1901. Dr. Horne mentioned that in one of the cases (microscopic sections of which were exhibited) he had found tubercle in a gland which presented the structure of lymphadenoma, and which was adjacent to the ulcer in the larynx; this, he considered, raised the question whether the ulcer in such a case and in the absence of tubercle in the lungs should be regarded as evidence of primary tuberculosis of the larynx.

Dr. FitzGerald Powell thought he understood Dr. Jobson Horne to say lymphadenoma was due to tubercular infection; he should like this explained.

In reply to Dr. FitzGerald Powell's question as to whether lymphadenoma and tuberculosis were to be regarded as one and the same disease, Dr. Horne said it was a point on which it was difficult to make himself clearly understood, for this reason: that tuberculosis was an entity, and lymphadenoma might also be one, but at present, no two people in discussing lymphadenoma seemed to be quite agreed upon what should be regarded as lymphadenoma. Dr. Horne said he recognised a distinct histological structure as characteristic of lymphadenoma; in that structure he had at times observed distinct

histological tubercle with giant-cells and tubercle bacilli; whether the lymphadenoma structure had been developed through the presence of tubercle, or whether the tubercle had been added to the lymphadenoma, there was not sufficient evidence at present upon which to base an answer.

Case and Specimen of Tubercular Rhinitis in a Man æt. 35, treated with Röntgen Rays.

Shown by Mr. L. Lawrence. The patient, a road surveyor, had been troubled with discharge from the nose for rather more than a twelvemonth. Some months ago he was treated with douches, first of boracic acid, and later of an alkaline lotion with some apparent benefit. Later the discharge returned, and on September 21st last the following condition was noted:—The whole septum, both sides and also both sets of turbinate bones were, as far as visible, greatly inflamed and covered here and there with yellow patches. The mucous membrane in many places was polypoid. In the floor of the nose on both sides the septum and inferior turbinals were pressing against each other. There was abundant offensive discharge from the nose. A piece of polypoid mucous membrane was removed for microscopic examination, and well-marked tubercle (exhibited) was shown. The man's general health had been good all along, but he had had severe supra-orbital neuralgia and some pain in the eyeballs. Treatment by exposure to Röntgen rays had been tried since September. The patient had had twenty-one applications, varying from seven to ten minutes each. His symptoms had considerably abated, and there was much less swelling in the nose than formerly. The pain also had gone from eyes and forehead, and the patient now expressed himself as feeling more comfortable.

Dr. Hugh Walsham explained the technique of the treatment of such cases with Röntgen rays.

Dr. Herbert Tilley wished to suggest in connection with this case that if after twenty-three applications of the Röntgen rays, administered by such an expert as they knew Dr. Hugh Walsham to be, the improvement was not more marked than it appeared to be in this case, it was high time to proceed to other and more drastic

measures of treatment. He suggested thoroughly curetting the ulcerated surface under general anæsthesia, followed by the rubbing in of pure lactic acid. The application of the Röntgen rays was a very interesting form of treatment which one would like to see more often applied to difficult cases of lupus of the inside of the nose, especially in the earlier stages of the disease. He could conceive that it might produce good results, similar to those obtained in lupus of the skin. He did not know how bad this case was when it was first seen before the rays were applied, but it was obvious that it must have been an exceedingly bad one if the present condition of things was supposed to be one of great improvement.

Mr. DE SANTI had recently had two such cases under his care in the out-patient department; they were both tubercular affections of the nose. One was treated by the Röntgen rays and the other he was treating with urea (ten grains to the ounce of water). He was bound to admit that the latter treatment had been much more effective than the former. The urea was taken internally, and local treatment was also applied to the interior of the nose of the nature mentioned by Dr. Tilley (scraping, lactic acid, etc.). He had also had very satisfactory results in cases of tubercular glands of the neck treated by the internal administration of urea.

Dr. STCLAIR THOMSON suggested that as primary tuberculosis of the septum was very rare, Mr. de Santi should put his cases on record. There were only seven cases in British literature bearing on the subject. Six of these were reported by Mr. Steward, of Guy's Hospital,* and the seventh by himself.† His authority for this statement was Renshaw of Cambridge, who searched the literature in connection with some animal experiments in which tuberculous matter was inoculated into the nose ('Journal of Pathology,' vii, No. 2, 1901, p. 142). These seven cases did not include lupus. His own case was shown at the Clinical Society, and he had watched it for four years. The treatment had, to a great extent, been palliative, and its condition was now much better than the one they had just seen in the adjoining room. The treatment in his own case consisted of cleanliness, with a little curetting, the use of lactic acid, and general hygiene. The patient objected so strongly to the curette, and was so positive that she was better without it, that he had not pressed it. The same patient was treated by Dr. Watson Williams at the Bristol Infirmary with tuberculin, to which she reacted violently according both to her own account and that of Dr. Watson Williams, and she was no better for it. He had not seen the patient now for a year, but the progress of the disease was extremely slow, and at that time her condition was very comfortable.

Mr. DE SANTI, in reply to Dr. Thomson, said his cases were not primary tuberculosis of the nose, but cases of lupus, which he included in the designation "tubercular."

The PRESIDENT regarded the case as one of chronic tuberculosis of the nose; such cases were not uncommon. As regards the light

* 'Guy's Hosp. Rep.,' vol. liv.

† StClair Thomson, 'Clin. Soc. Trans.,' October, 1897, and February, 1900.

treatment, he had had a case of this description which he saw in the spring, in which the patient received eighteen applications of Finsen's light treatment for spots of lupus outside the nose, and twenty applications of X rays. The former seemed to do some good. Of the X rays he could not speak so decidedly; if they had any effect at all in this case, which had been previously treated by curetting, lactic acid, etc., it was in making the parts look more glazed and drier. As regards the internal administration of urea, he mentioned that his colleague, Mr. Buck, had obtained good results from it in lupus of the skin. He himself had tried it in one case of tuberculosis of the nose, and had given it for about four months. The nasal mucous membrane had been previously curetted and treated with lactic acid, and the patient expressed herself as very satisfied with the urea treatment; at any rate, no re-growth had occurred, although there had been no scraping for some months, only applications of lactic acid. It was impossible, of course, to draw any conclusions from a single case of this character; a large number would require to be treated before an estimate of the value of urea given internally could be formed, and it should, if possible, be tried on cases that had not been submitted to local treatment. With regard to the case under discussion, he thought thorough curetting was necessary, or else a further course of the Röntgen rays. Personally he would advise the former, and then apply lactic acid in the usual way. The Society were much indebted to Mr. Lawrence for bringing forward such an interesting case, and also to Dr. Hugh Walsham for explaining the method and technique.

Mr. Lawrence said: "As regards the treatment of the case, of course the obvious thing at present would be to curette it and rub in some lactic acid. I think, looking to the fact that the Röntgen rays have done considerable good, and that there is really no great urgency in the case, and that it is improving slowly, it is worth while trying the rays for a little longer, especially as Dr. Walsham is willing to go on with the treatment to see how it answers. On a future occasion I will, if you will allow me, bring the patient before you again."

Case of Complete Loss of Internal Framework of the Nose in a Girl æt. 22.

Shown by Dr. Cathcart. The patient was quite healthy up to the age of thirteen. She then contracted scarlet fever, followed by inflammation in the nose, which resulted in complete loss of all the internal nasal structures. The bridge of the nose had fallen in, and Dr. Cathcart would like to have the opinion of any member who had had experience of the subcutaneous injection of paraffin as to whether this was a suitable case for such treatment.

Dr. SCANES SPICER had had one case in which he had injected vaseline under the skin of the nose for a very similar deformity. The only disadvantage which followed was that some of the paraffin worked its way into the upper eyelid. He had shown the casts of the nose before and after treatment, and photographs at the meeting of the British Medical Association at Cheltenham this year. Within the last few weeks he had handed over the patient to the ophthalmic department to see if it were practicable to remove the paraffin from the subcutaneous tissue of the lid; but having made an incision, Mr. Keeling had not been able to improve matters, and so the puffiness of the lids remained. He hoped to show the photograph and the patient at the January meeting of the Society if possible. The technique for inserting the paraffin into the nose was rather troublesome. He used just such a small syringe as used to be used for tuberculin injections. He heated the paraffin in a water-bath, and had the patient standing near. Having sterilised the skin with alcohol and sublimate solution, he injected three or four syringefuls of the paraffin into the subcutaneous tissues over the middle of the nasal bridge, and moulded the mass up with the fingers to the shape of a normal nose. The point of injection was sealed with collodion. In future he would inject only a small amount at one time, and repeat as necessary, and he would press down the skin at root of nose on to the subjacent tissues, so that nothing could escape, at all events at time of injection. He thought Dr. Cathcart's case was a suitable one, because the skin was so freely moveable, and a bolster of paraffin between the skin and the bridge would make a presentable nose. The paraffin in his own case had now been *in situ* six or seven months, and it was really wonderful how well it filled up the depression which had previously existed in the bridge. Before commencing treatment the condition was quite as bad as that now seen in Dr. Cathcart's case, whereas now there was really quite a decent bridge, though the feature was not of an ideally refined type.

In reply to Dr. Tilley, Dr. SPICER stated that the paraffin used melted at 105° or 106° F., and was sterilised. It was a mixture of lard and soft paraffin, as first recommended by Dr. Gersuny of Vienna.

Dr. STCLAIR THOMSON asked if there were not some doubt as to this case being the result of scarlet fever. He saw the words used to describe the case were "after scarlet fever." Did the history point indubitably to this destruction being the result of scarlet fever? Perhaps members with a greater experience than he possessed would tell the Society whether it was ever a recorded occurrence for the bony framework of the nose, or even part of it, to be destroyed by scarlet fever.

Dr. S. SNELL thought that the patient had been the subject of interstitial keratitis; there was also scarring at the right angle of the mouth, and he was therefore of opinion that this was a syphilitic lesion, perhaps lighted up by the scarlet fever.

Dr. CATHCART was much obliged to Dr. Scanes Spicer for the description of the technique he had given, and for the results of his experience, and if he decided to inject paraffin he would take advantage of the latter, and try and prevent the paraffin going into the lids.

With regard to what Dr. StClair Thomson had said in reference to the ætiology, according to the description given him, the affection came on immediately after or during an attack of scarlet fever.

With reference to a specific origin, there was a small leucoma on the corneal periphery below, in the right eye, but it was confined to one eye and was not interstitial keratitis, but a leucoma following an ulcer.

Case of Mal-development of the First and Second Branchial Clefts.

Shown by Dr. Cathcart. The patient, a boy æt. 8, has mal-development of the first and second branchial clefts on the right side. There is a rudimentary auricle, slight facial paralysis, and a sinus halfway down the anterior border of the right sterno-mastoid. There is also marked hydrocephalus.

Case of Epithelioma of the Epiglottis in a Middle-aged Man.

Shown by Mr. E. Waggett. This was a case of slow-growing epithelioma involving the cervical glands. It was brought forward as one in which divergent opinions might be expressed as to the possibility of radical operation.

Sir Felix Semon did not think this a case suitable for operation. The disease was very extensive, and had infiltrated the pharyngeal wall on both sides; there were also large glands on both sides. Even if it were possible to remove the disease entirely, which he doubted, rapid recurrence would be unavoidable.

Mr. de Santi fully agreed with the remarks of Sir Felix Semon. He did not think in that particular case it would be possible to get away the whole of the disease. It should be left entirely alone.

Case of Cicatricial Stenosis of the Pharynx in a Young Woman, the Sequel of Cut Throat inflicted Eighteen Months previously.

Shown by Mr. Waggett. Deglutition and respiration were embarrassed by a firm web binding the epiglottis to the posterior wall of the pharynx. A cutting operation through the mouth had been followed by some dyspnœa, and it was now proposed to perform laryngofissure.

Case of Paralysis of the Left Vocal Cord in a Woman æt. 42, probably of Specific Origin.

Shown by Mr. de Santi. The patient had suffered from embarrassed breathing for from three to four months; she had also had a bad cough during the last six months. There were well-marked tertiary scars about both legs, and her last baby, born five years ago, had had snuffles, etc. Examination of the larynx showed well-marked paralysis of the left vocal cord, otherwise the larynx was normal. There was no swelling in the neck to be discovered, and examination physically of the chest had been negative. The case looked, however, like one of thoracic aneurysm with pressure on the left recurrent laryngeal nerve, and this would tally with the history of syphilis. (Subsequent to the meeting the thorax was examined by the rays, and a dilatation of the arch of the aorta easily made out.)

Case and Specimen of Fibroma of Nasal Vestibule.

Shown by Mr. W. H. Kelson. The patient, a man, came to hospital complaining of a tumour which blocked the left side of his nose and produced considerable deformity. He had noticed it for about ten years. It looked and felt like a cyst. An incision was made through the skin of the vestibule, where the growth appeared to take origin, and it was enucleated. The tumour, which was about the size of a small hen's egg, was solid, and microscopically was seen to be a fibroma. Patient had had one or two similar tumours removed from other parts of his body. The side of the nose previously blocked was now pervious, and the deformity had quite disappeared.

Case of Sublingual Dermoid Cyst in a Male æt. 17.

Shown by Dr. Wyatt Wingrave. The symptoms were chiefly discomfort in deglutition and speech of about two months' duration. The swelling was visible on each side of the frænum

linguæ of a somewhat purple colour. It projected below the mandible, fluctuated, and was painless.

It was opened nine days ago on the left side of the foramen, releasing at first a small quantity of clear thin fluid with a few white flakes. On digital pressure about two ounces of white pasty matter, resembling German yeast, was evacuated. This mass was not fœtid, and consisted microscopically of amorphous fat granules and epithelial squames.

Part of the capsule, which was deeply situated and very thick, was excised, and the cavity, which extended under the tongue between the genio-hyoglossal muscles, was scraped and swabbed out with pure phenol.

The foramen cæcum was not well marked, and although the cavity extended closely to it, no actual communication could be made out.

The contents conformed in every respect with cholesteatomatous cysts of the auricle.

A similar case was recently under his care in private, in the person of a young athlete æt. 22. The history, anatomy, and treatment were exactly like the present case, but it healed without suppuration, and had caused no further trouble, there being no signs of its existence eight months after operation.

Case of Tubercular Larynx with Fixation of the Left Cord.

Shown by Mr. C. A. Parker. The patient, a man æt. 29, complained chiefly of hoarseness. On examination there was found to be some general chronic laryngitis, but the more marked pathological changes were confined to the left side of the larynx. The left cord was infiltrated, ulcerated, and fixed, and there was a red fleshy swelling springing from the left ventricular band.

The patient had been losing flesh slightly, and there were signs of commencing phthisis at the left apex.

Just before coming to the meeting Mr. Parker had learned that the case had previously been brought before the Society by Dr. Furniss Potter in June last.* There were then no signs of phthisis, and the cord was freely moveable.

* See 'Proceedings,' vol. viii, p. 141.

Dr. Clifford Beale stated that when he examined this case he certainly thought that the left cord moved as well as could be expected in a patient the subject of that amount of disease. He did not think it was fixed when he saw it. It quite fell into one's ordinary experience of unilateral tubercular disease in the larynx when comparatively acute. Sometimes in such conditions the cord worked well and sometimes not. Very often in consultation one had a little indecision in these cases as to whether the cord was fixed or not, but after observing it for a short time one generally came to the conclusion that the damaged cord moved very much like an arm when damaged, *i. e.* sometimes better than at other times, but at all times badly and stiffly. With regard to the question of fixation as the result of tubercular disease, he thought it would be better to exercise care in reporting and describing these cases if there was a doubt as to the absolute fixation. Such a case as the one under discussion, if so described, would make it appear that the Laryngological Society of London recognised fixation of the cord as one of the natural sequences of tubercular disease of the larynx. He ventured to say that the Society would not give their assent to that opinion. He had not yet seen any case put on record to prove that fixation of the crico-arytænoid joint did occur as a direct result of tubercular disease.

Mr. C. A. Parker said in reply that he quite agreed with Dr. Clifford Beale that there was not absolute fixation of the cord; "impairment of movement" would have been a more correct description. At times, however, he thought the cord refused to act at all.

Case of Re-growth of Malignant Disease in a Man æt. 52, after Partial Removal by Laryngofissure.

Shown by Dr. StClair Thomson. This patient was shown to the Society in June last (*vide* 'Proceedings,' vol. viii, p. 136), with a growth involving the anterior four fifths of the right cord, and the anterior third of the left. It was then generally agreed by members that the growth was malignant and suitable for thyrotomy. This operation was undertaken on June 18th, and as soon as the skin incision had been carried down to the front of the larynx it was seen that the disease was much more extensive than any one had suspected. The glands in front of and alongside the larynx were infiltrated and the muscles even were affected, while the thyroid cartilage itself had broken down in the middle line. It was noteworthy that no one who had seen the case beforehand had suspected this malignant perichondritis, though possibly it was indicated by a red fleshy

granulation below the cords in the anterior commissure. (This was indicated in a drawing handed round, made by an artist the day before the operation.)

In spite of the extension of the disease beyond the confines of the cartilaginous voice box it was thought desirable to give the man any benefit of doubt, and all the soft parts inside of the thyroid cartilage were widely removed, the cartilage being left bare on each side and the cords removed right back to the arytænoids. The infiltrated parts of the cartilage in front were cut away.

One interesting point was to note how well the patient stood the operation. That evening his temperature was 100·8°, but the next day it was only 99·4°, and it never rose higher. He swallowed water on the evening of the operation. The next day he sat out of bed for four hours, and forty-eight hours after the operation he was swallowing solid food, such as eggs and bread and butter.

The neck wound healed well, and he gained a fair whispering rough voice from the development of cicatricial tissue in the larynx into pseudo-vocal cords. At the end of July he appeared fairly well.

He did not come under observation again until November 30th, when the growth was seen to have re-grown on the right side, where an enlarged gland is to be felt.

The growth removed was reported by the pathologist to be epithelioma.

The patient now weighed fifteen stone and had remained these six months in the enjoyment of good general health, and no local discomfort beyond the diminished voice power.

Sir FELIX SEMON would make a further attempt, for it seemed to be a pity that nothing more should be done. The disease still appeared to him limited enough, so that a second operation of the same sort might be more lastingly successful than the first one had been.

Mr. DE SANTI understood from Dr. StClair Thomson that when operating enlarged glands were found, and also some glands which were not usually described, namely, one or two in the front of the larynx—the prælaryngeal glands. It would be interesting to find out whether these glands, which were removed at the time of operation, were infiltrated with epitheliomatous disease. If so—and it was presumable they were involved—one would not get any really good results from a

second operation, as recurrence would undoubtedly take place rapidly. Moreover the disease was very extensive, and it was a question whether its limits could be at all defined. In his opinion, therefore, it was not a suitable case for secondary operation.

Dr. Lambert Lack did not think further operation advisable. The growth had spread to the arytænoid and anterior wall of the pharynx. If operation were decided on, the case required total extirpation of the larynx and part of the pharynx as well.

Sir Felix Semon said he should like to know why extirpation of the whole larynx was recommended by the last speaker. There was no evidence of the return of the disease on the left side. In other respects the man was in a good state of health. If he personally was in this man's unfortunate position, he would rather undergo a second operation than go certainly downhill, as must otherwise be the case.

In reply to Sir Felix Semon, Dr. Lack said the chief point in favour of extirpating the whole larynx was that the mortality of cases in which half the larynx had been removed was very much greater than that of cases in which entire removal had been done. He further thought that total extirpation would give a better chance of freedom from recurrence.

Dr. StClair Thomson said he had not seen the patient since the end of last summer until a few days ago, but after some discussion of the case in the next room the history came back to his memory. He was speaking now without having recently looked up his notes. When he made the first incision at the operation, he came down at once, as Mr. de Santi had mentioned, upon some glands in the neck which were distinctly infiltrated. They were situated over the crico-thyroid membrane. The thyroid cartilage itself was also involved, and was ulcerated so much that he resected portions of it, and clipped away a lot of muscle which appeared to be infiltrated. The pathologist reported that the growth was epitheliomatous. The disease had spread very much more than was suspected before operation. He agreed with Dr. Lack that it seemed to him the disease had spread through the arytænoid, and very possibly to the side of the pharynx quite close to the tongue, and so he thought an operation of any sort was almost hopeless, especially when one bore in mind the extra-laryngeal conditions found at the laryngofissure six months ago.

Case of Complete Paralysis of the Right Vocal Cord in a Man æt. 33.

Shown by Mr. E. W. Roughton. The patient had well-marked physical signs of phthisis and a small deep-seated swelling in the right side of the neck, which Mr. Roughton thought was a mass of tuberculous glands involving the recurrent laryngeal nerve.

Dr. CLIFFORD BEALE had some doubt as to the absolute paralysis of the right cord here, for he saw it move to a certain extent.

Dr. FITZGERALD POWELL said there did not appear to be any tubercular disease in the larynx, but he thought the cord was quite paralysed; it was suggested that this was a case of fixation or paralysis of the cord from enlarged tubercular glands in the neck pressing on the recurrent laryngeal nerves, and this he thought to be the case.

Dr. SCANES SPICER thought the condition one of immobility from paralysis of nerves rather than organic fixation. He could not detect any movement whatever in this case, whereas he agreed with Dr. Clifford Beale as to the previous case shown as paralysis of cord that there was now considerable movement.

In reply Mr. ROUGHTON said he did not think there had been any tubercular disease of the larynx at all.

CASE OF HOARSENESS IN A CHILD ÆT. 1 YEAR AND 10 MONTHS.

Shown by Mr. E. W. ROUGHTON. In this case Mr. Roughton had been unable to obtain a view of the larynx.

Dr. SCANES SPICER considered that this was a very suitable case for trying the method of general chloroform narcosis with simultaneous local application of cocaine. He continued to find this combined anæsthesia invaluable in a large number of cases of laryngeal trouble in children in which it was essential to examine or operate on the larynx.

The PRESIDENT would advise trial of an examination with cocaine, using a tongue depressor and small laryngeal mirror. During respiration a momentary view of the glottis might be obtained.

Dr. LAMBERT LACK thought it would be quite easy to examine the child with the aid of his tongue depressor without using either chloroform or cocaine.

The PRESIDENT said he knew Dr. Lack's method, but had not always found it successful.

GROWTH IN LARYNX IN A CASE OF SYPHILIS (FOR DIAGNOSIS).

Shown by Dr. H. LAMBERT LACK. This patient, a woman æt. 37, has been under treatment for a month with ulceration of the left vocal cord, fixation of the left side of the larynx, and a fleshy growth springing from the anterior commissure. There is extensive scarring of the palate attesting former syphilis. In spite of large doses of potassium iodide (gr. xxv ter die) the

laryngeal growth is increasing rapidly. The case is shown for suggestions as to diagnosis and treatment.

Dr. StClair Thomson said that pieces of the growth had been punched out, and so it was impossible to say clinically what it might be. He would like to hear the microscopist's report, as it might be tubercle, syphilis, or almost anything. At present it was only an ulcerated thickening.

Case of Swelling of Left Side of Nose (for Diagnosis).

Shown by Dr. Furniss Potter. The patient was a woman æt. 49, who stated that the swelling in her nose had been developing for the last four years. She had had pain at times, and some discharge. There was no history of syphilis. On examination the left side of the nose was seen to be considerably swollen externally, the mucous membrane of the left nasal fossa was swollen, and bled very readily on being touched. The septum was much thickened and presented two perforations, one behind the other.

Dr. FitzGerald Powell said he thought that this was a case of breaking-down gumma or tubercular abscess, but the perforation of the septum led one to suspect a specific origin. On making firm pressure on the swelling outside, pus was distinctly seen coming from a sinus on the inside of the nose.

Dr. StClair Thomson thought the condition of the septum suggested tuberculosis much more than syphilis, and that a portion of the hypertrophy might be removed and examined microscopically. It was a sort of thickening that could not be easily described, and was similar to the tuberculous case he had referred to earlier. The patient under discussion had had for four years a thickening of the skin on the nose, and he did not think it likely that a node could remain *in statu quo* as long as that.

The President agreed with Dr. StClair Thomson in believing the swelling looked more like tuberculosis. A piece should be scraped off and examined under the microscope.

Dr. Furniss Potter would act on the suggestions made, and obtain a scraping from the nose and have it examined microscopically.

Case of Stenosis of the Pharynx.

Shown by Mr. C. A. Parker. The patient, a woman æt. 37, stated that when ten years old she had an abscess in the neck

followed by trouble in the throat which caused her to talk thickly. She was then and for many years afterwards under the care of the late Sir Morell Mackenzie. There was no history of scarlet fever and there were no definite signs of hereditary syphilis.

On examination, the tonsils and posterior pillar of the pharynx were seen to be bound down to the posterior wall of the pharynx; lower down the epiglottis was adherent to the pharynx, leaving a small circular opening not much bigger than a threepenny piece. On strongly depressing the tongue the opening could be seen by direct vision as a narrow vertical chink about half an inch long and an eighth of an inch wide. The patient had no difficulty in respiration and but little in deglutition; she could swallow solids, but occasionally fluids "go the wrong way."

The PRESIDENT said this case reminded him of one he had shown some years ago at the Society—a young person with stenosis of the lower part of the pharynx (see 'Proceedings,' vol. i, p. 9).

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

ANNUAL MEETING, *Friday, January 10th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

Present—18 members.

The minutes of the last Annual Meeting were read and confirmed.

Drs. H. Sharman and Braine-Hartnell were appointed scrutineers of the ballot, and the following officers were appointed for the year:

President.—E. Cresswell Baber, M.B.

Vice-Presidents—E. Clifford Beale, M.B., F.R.C.P., and F. W. Bennett, M.D., and Dundas Grant, M.D.

Treasurer.—William Stewart, F.R.C.S.Edin.

Librarian.—StClair Thomson, M.D., F.R.C.S.

Council.—F. de Havilland Hall, M.D., F.R.C.P.; Sir Felix Semon, M.D., F.R.C.P.; H. Lambert Lack, M.D., F.R.C.S.; Richard Lake, F.R.C.S.; Ernest Waggett, M.B., and J. Barclay Baron, M.B.

Secretaries.—Charles A. Parker, F.R.C.S.Edin., and James Donelan, M.B.

The report of the Council was then read and unanimously adopted.

REPORT OF COUNCIL.

The past year has been marked by the deep sorrow of the Society at the lamented death of Her late Majesty Queen Victoria, the respectful expression of which was graciously acknowledged by His Majesty King Edward.

The Council has the pleasure to report that the Society continues in all respects in a most prosperous condition.

At the last Annual Meeting the rules, as revised by the late Council, were unanimously adopted. These rules include special

provisions with regard to the qualifications for membership of the Society, and in consequence only five new members have been elected during the year.

The meetings have been well attended and the clinical material has been both interesting and abundant. By the exclusion of academic matter from the first section of each meeting the transaction of business has been facilitated.

The following report of the Treasurer was read and adopted:

During the past year the Society's receipts from all sources amount to £143 17*s*. 10*d*. Several members have neglected to pay their subscriptions for 1901, but most of the outstanding subscriptions referred to in the Financial Report of last year have now been paid in.

The total expenses have amounted to £140 10*s*. 10*d*., thus leaving an excess of income over expenditure of £3 7*s*. for the year. To this has to be added the balance brought forward from last year, viz. £216 11*s*. 1*d*., making a total credit balance on January 1st, 1902, of £219 18*s*. 1*d*. Of this amount £200 has been placed on deposit with the Society's bankers during the past year.

The Balance Sheet, duly audited and found correct by the auditors, Dr. FitzGerald Powell and Mr. L. A. Lawrence, is appended.

BALANCE SHEET, 1901.

Income.	£	s.	d.	Expenditure.	£	s.	d.
7 Entrance Fees	7	7	0	Rent	31	10	0
113 Subscriptions	118	13	0	Adlard—Printing	68	15	6
10 „ (1900)	10	10	0	Reporting	16	16	0
1 „ (1899)	1	1	0	Baker—Microscopes	1	18	0
Sale of 'Proceedings,' Reading-cases, etc., per Hon. Librarian	2	2	0	Pulman—Binding	3	6	0
				Annual Dinner	10	2	0
Interest on Deposit	4	4	10	Clarke—Indexing	1	10	0
				Mathew (porter)	2	0	0
Cash on Deposit £200 0 0				Tongue-cloths	0	12	6
Balance brought forward from 1900 16 11 1				Carbolic acid, etc.	0	7	3
Balance Jan. 1st, 1901 3 7 0				Hon. Secretaries' Expenses	1	6	6
				Hon. Treasurer's Expenses and petty cash payments	1	4	6
Total Credit Balance 219 18 1				Bank charges	1	2	7
				Total Expenditure for 1901	140	10	10
				Balance	3	7	0
	£143	17	10		£143	17	10

Dec. 31*st*, 1901. Audited and found correct, { H. FITZGERALD POWELL. L. A. LAWRENCE.

E. CLIFFORD BEALE, *Treasurer*.

The Librarian's report was then read and adopted.

The following "Exchanges" have been regularly received during 1901:

Journal of Laryngology.
The Laryngoscope.
Revue Hebdomadaire de Laryngologie, d'Otologie, et de Rhinologie.
Annales des Maladies de l'Oreille, du Larynx, du Nez, et du Pharynx.
Monatsschrift für Ohrenheilkunde.
Archiv für Laryngologie.
Archives Internationales de Laryngologie, d'Otologie, et de Rhinologie.
Archivii Italiani di Laryngologia.
Bollettino delle Malattie-dell' Orecchio, etc.
Archivio Italiano d'Otologia.

Arrangements have been made for the exchange with the French journal 'La Parole,' edited by Dr. Marcel Natier.

The following works have been added to the library during 1901:

Presented by Dr. de Havilland Hall.

Fränkel, Prof. Dr. B. Adenoide Vegetationen. (Separat-Abdruck aus der Real-Encyclopädie der gesammten Heilkunde.)
" " Angina. (Separat-Abdruck aus der Real-Encyc., etc.)
" " Die Demonstrationen des laryngoskopischen Bildes. (Sonderabdruck aus Therapeütische Monatsschrift-herausgegeben von Dr. Oscar Liebreich.)
Lange, Victor. Sur l'emploi de la Méthode galvano-caustique dans le Nez et le Pharynx. Remarques présentés à la sous-section de laryngologie dans la 7e session du Congrès International des Sciences Médicales (Londres, août 1881).
Mygind, Dr. Med. Holger. Die angeborene Taubheit. Beitrag zur Aetiologie und Pathogenese der Taubstummheit.
Scheppegrell, Wm., A.M., M.D. Congenital Occlusion of the Posterior Nares.

The following have been presented by their authors:

Bar, Dr. Louis. De la Tricophyte du Conduit auditif externe. (Extrait des Annales des Maladies de l'Oreille, etc.). 2 copies.
Downie, Walker, and Kennedy, Robert. Two Unusual Cases of Stricture of the Œsophagus.
Downie, Walker. Four Cases illustrative of the Local Lesions resulting from the swallowing of Liquid Ammonia.
" " Two Examples in Men of severe and prolonged Attacks of Asthma, associated with, and apparently dependent upon, the presence of Nasal Polypi, extirpation of which resulted in complete Immunity from Asthmatic Symptoms.
Hall, Dr. de Havilland, and Tilley, Dr. Herbert. Diseases of the Nose and Throat.
Joris, Dr. Alois. Ueber die Anwendung des Menthol-Jodols in der rhino-laryngologischen Praxis.
Krieg, Dr. Robert. Atlas der Nasenkrankheiten von Hofrat. (Specimen containing Tafel VI.)
Gougenheim, A., and Lombard, E. de Paris. Indications opératoires dans le Cancer du Larynx. (Extrait Annales des Maladies de l'Orielle, etc.) 2 copies.
Natier, Dr. Marcel. Syphilis tertiaire du Nez chez une jeune Fille: Infection au cours de l'allaitement par la nourrice; sequestres et polypes muqueux. (Avec 4 figures dans le texte.) 2 copies.
Ropke, Dr. F. Three cases operated on for Otitic Abscess of the Temporal Lobe, with Fatal Result.
Williams, Dr. Watson. Diseases of the Upper Respiratory Tract. (Fourth edition.)
" " The Therapeusis of Gonorrhœal Urethritis, with special reference to Gonal (published by F. Williams and Co.).

Williams, Dr. Watson. The Treatment of Tuberculosis and Catarrhal Conditions of the Respiratory Organs by the Isovalerianic Acid Ester of Creosote and the Eosolate of Quinine (published by F. Williams and Co.).

The following PROCEEDINGS OF SOCIETIES, etc., have also been added:

Jahrbücher der Gesellschaft der ungarischen Ohren- und Kehlkopfärzte (Dr. Ludwig Polyak).
Sitzungsberichte der Gesellschaft der ungarischen Ohren- und Kehlkopfärzte (Dr. Hugo Zwillinger), 1901. No 1 (2 copies) and No. 2.
Sitzungsberichte der Wiener Laryngologischen Gesellschaft, 1900.
Transactions of the 22nd Annual Meeting of the American Laryngological Association, 1900.
Brighton and Sussex Chirurgical Society, 1900–1.
Niederländische Gesellschaft für Hals-, Nasen-, und Ohrenheilkunde, Arnheim, 1901.
Catalogue of Accessions to the Library of the Royal College of Physicians of London, 1901.
Fourteenth Congrès International de Médecin—Rules.
British Congress on Tuberculosis—Programme.
Société Française d'Otologie et de Laryngologie, Réunion annuelle, mai, 1901.

At an informal meeting consisting of the ex-librarians, Dr. de Havilland Hall and Dr. Clifford Beale, the outgoing librarian, Dr. Dundas Grant, and the nominate librarian, Dr. StClair Thomson, with Sir Felix Semon, inspected the unbound material in the library of the Society and a number of papers which had little or no bearing upon the work of the Society were laid aside for elimination. The librarian trusts that the Society will approve of their recommendation being carried into effect.

The library has now attained such dimensions that the accommodation for it at the rooms of the Royal Medical and Chirurgical Society is quite inadequate. In order to relieve subsequent librarians of the necessity of finding space for it, the present librarian recommends that some arrangement should be made for its accommodation. He would also advise that a catalogue should be printed and placed in the hands of the members of the Society, and spaces or leaves introduced on which they could add the names of whatever additions are made from time to time; he is convinced that in this way the use of the library would be much greater than it is at present.

The meeting then adjourned.

SEVENTIETH ORDINARY MEETING, *January 10th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

ERNEST WAGGETT, M.B., CHARLES A. PARKER, F.R.C.S.(Ed.), } Secretaries.

Present—34 members and 1 visitor.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for the election of the following candidates, who were unanimously elected:

As Honorary Member:

Thomas James Walker, M.D.Lond., of Peterborough.

As Ordinary Members:

A. Stanley Green, M.B., B.S., 9, West Parade, Lincoln.
James M. Browne, M.B., 27, Wellington Road, Cork.

The following cases and specimens were shown:

SPECIMEN OF A PEDUNCULATED ANGEIOMA OF THE LARYNX.

Shown by Dr. BRONNER. The patient, a strong, healthy man æt. 63, was seen in June, 1901. For the last twenty years the voice had been slightly hoarse, and he could not speak for any length of time with comfort. Five months ago the voice suddenly became very hoarse, and had remained so ever since. There was no dysphagia or dyspnœa. A large red raspberry-shaped growth was seen in the glottis, about the size of a marble; only a small part of the vocal cords was visible. A piece of the growth was removed for examination. The Clinical Research Association reported: "This seems to be a nævoid growth in the mucous membrane, which is ulcerated in the centre and become consolidated with fibrin and exudation.

The vascular channels in the deeper tissues are large and numerous."

The growth was removed by Fränkel's forceps. There was now a small red swelling in the anterior part of the left vocal cord, but otherwise the larynx seemed to be normal. The voice was better than it had been for twenty years, and up to the present there had been no recurrence.

Mr. P. DE SANTI said that from the general appearance of the growth under the microscope there was, in his opinion, no doubt that it was a tumour of the nature of nævoid tissue, and that the case was one of "pedunculated angeioma." He understood that Dr. Bronner wanted to know if the Society agreed with his diagnosis.

CASE OF A FEMALE WHOSE SADDLE NOSE HAD BEEN TREATED BY SUBCUTANEOUS INJECTION OF VASELIN (PARAFFIN), WITH CASTS AND PHOTOGRAPHS TAKEN BEFORE AND AFTER TREATMENT.

Shown by Dr. SCANES SPICER. The patient, æt. 25, had applied for treatment for nasal suppuration and fœtor, which had lasted from childhood. There was a negative history as to traumatism or acquired syphilis, but some doubt as to evidences of congenital taint. She had a well-marked tip-tilted saddle nose and stunting of the nasal framework. Crescentic wrinkles from eye to eye over the bridge of the nose were well marked, as seen in Cast No. 1, taken the day before injection (May 6th, 1901). In addition to ordinary methods of treatment for nasal suppuration, the speaker suggested improving the shape of her nose by injecting sterilised vaselin as first described by Gersuny of Vienna. He had obtained the result indicated by Cast No. 2 and Photo. No. 2 (taken end of July, 1901).

The paraffin used was a mixture of hard and soft paraffin made to meet at 40° C. (105° F.), previously sterilised and kept in sealed bottles. The skin of the nose, etc., was cleansed first with alcohol and then with Liq. Hydrarg. Perchlor. The syringe and needle were cleansed and boiled in the steriliser, which was also used as a water bath to heat the paraffin. A German glass hypodermic syringe was used, like that for injecting tuberculin. Ten to twelve syringefuls were injected, some

downwards over nasal bends, some upwards from the sides of the nose into the depressed gap, and the injected matter was moulded by an assistant's fingers so as to shape the part before setting. The skin was again cleaned and the points of injection sealed up with collodion. The syringe was removed for refilling from the socket in the needle, which, when once *in situ*, was allowed to remain there until it was judged that enough vaselin had been injected at that spot. There was no pain, though the nose looked a little tense and brawny. No paraffin passed into the eyelids apparently at the time. There was afterwards no pain nor inflammation, but in a few days the upper eyelids became somewhat œdematous. This had varied in amount from day to day ever since, and in left upper eyelid was a little nodule the size of a large shot. This had been cut down on, but it did not appear possible to get it out.

The result, as far as the appearance of the nose went, was very palpable, the skin over the bony bridge of the nose being bolstered up, produced a very decent-sized organ. As it was done eight months ago and now remained in the same state as when first injected, it might be regarded, as far as could be seen at present, as permanent. It was certainly a great improvement to her appearance, and the patient states that her mother was "proud of her in her altered condition." The patient indeed alleged that there had been an improvement in her general health and nasal suppuration since, but that was doubtless due to the general tonics and nasal washes she had used. The passage of a nodule of paraffin into the upper eyelid was disappointing, and so was the œdema of the lids. The former was not improbably due to the physiological action of the pyramidalis nasi, which would tend to shift movable bodies upwards and into the orbit. The latter might be due to a blockage of lymphatic vessels by the paraffin, some of which had probably got divided up into a molecular condition. It should be remarked, however, that the upper lids were inclined to be puffy before the injection. There was no œdema elsewhere in the body. In any future case Dr. Spicer thought still more care should be taken to put pressure on the root of the nose at time of injection, and he suggested that repeated injections of smaller quantities would in all probability be better than doing all at once. The method

appeared to offer many advantages over plastic operations for this class of case. Gersuny injected cocaine before injecting the vaselin, but this, he thought, could be hardly necessary in nasal cases, as the only pain was the prick of the needle. In some of his cases of filling up cavities or formation of an artificial protuberance the effect produced by the vaselin had remained unaltered in shape or size for many months, the paraffin apparently having become encapsuled.

The PRESIDENT thought it a very interesting case, and would like to hear if anyone else had experience of the method. The paraffin injection seemed worth trying in such cases, provided precautions were taken to prevent the paraffin from running into neighbouring parts.

Mr. P. DE SANTI suggested that in treating these cases a piece of lead sheeting should be applied over the parts adjacent to the root of the nose, and firm pressure exerted on it during the injection of the paraffin. This method he had used successfully for removal of cirsoid aneurysm of the scalp. Such a piece of lead, properly cut and shaped, and applied round the neighbourhood of the root of the nose would, in his opinion, prevent the particular accident that had taken place in Dr. Scanes Spicer's case. If this were done he would also be in favour of not removing the lead for some little time after the operation. As he understood from Dr. Spicer that the infiltration into the eyelids had not taken place immediately after the injection of the paraffin, but some time afterwards, it would also be easy to keep up the pressure on the parts by means of the lead sheeting and bandaging. He congratulated Dr. Scanes Spicer on the fine nose he had made in this case.

Dr. BRONNER inquired if the paraffin had always been as soft as it was at present. He thought that by pointing the syringe downwards one would get over the particular difficulty that had arisen in this case. In a case of his own, which was similar to this, the nose was very much harder than that of the patient they had just seen, and his own difficulty was that immediately the paraffin was injected it assumed a certain shape, and retained that shape to such an extent that one could not mould it. Two or three weeks after the operation, in his own case, some inflammation set in. There was no pus, but the nose became red; in a few days, however, it settled down again to its normal state.

Dr. MILLIGAN asked what kind of paraffin had been used by Dr. Scanes Spicer, and what was the temperature at which it had been injected. It evidently was a very mobile paraffin.

Dr. LAMBERT LACK thought it might be possible to raise the skin and make a small cavity into which to inject the paraffin, instead of injecting it at random into the subcutaneous tissues. He thought the result in Dr. Spicer's case was excellent.

Dr. DONELAN said that with regard to preventing the rapid cooling of the paraffin, it might be possible to model a series of noses varying

from the most aristocratic and refined to the most vulgar in type, and have them made on the principle of the Leiter's coil, with a double chamber, so that the temperature might be maintained at that of the injection, and the nose given any desired shape.

In reply, Dr. Scanes Spicer said that he put the bottle containing the paraffin and the syringe into a water bath and heated it till it was just mobile. Such a small quantity as was injected must very soon cool down to the body temperature. The paraffin described by Gersuny was described in the Austrian Pharmacopœia as unguentum paraffinum. It is said to melt at 40° C., *i.e.* 105° F. Rogers, of Oxford Street, had prepared it for him (and from this firm it could always be obtained) in hermetically sealed bottles. He was very careful to ensure asepsis. There was not the slightest reaction of any kind after injection in his case. The nose was possibly a little tighter at first than it was now. About six drachms were required to form the "bolster."

With regard to Dr. Lack's remarks, he wished to say the paraffin was not injected "at random." The point of the syringe was put down where the chief part of the bolster was required, and then the paraffin was injected little by little and slowly, and the lump rose before one's eyes. But he thought that speaker's idea of first making an incision and then a kind of cavity with a blunt probe beneath the skin a very good one, and if he had another case he would cautiously try it. He feared, however, that bleeding might interfere with the operation. He tried to direct the shape of the bolster into that of a kind of omelette underneath the skin, between the skin of the nose and the bone. He had an assistant to help him while doing the operation, but the patient did not mind a bit, and did not even sit down for it.

Sequel to Case of Radical Cure of Multiple Suppurative Sinusitis and Polypoid Disease of Nose; Previously Exhibited April 10th, 1895, and January 8th, 1896.

Shown by Dr. Scanes Spicer. The patient, a male æt. 21, was first seen on November 4th, 1893, suffering from bilateral nasal obstruction due to polypi, accompanied by profuse suppuration. These conditions he had had for several years, for which repeated forceps operations had been performed. Lately he had lost 1½ stones in weight. Empyema of right antrum was indicated by symptoms, and corroborated by transillumination and by exploration through the canine fossa and irrigation. A day or two later the pus had collected near site of puncture and formed an abscess, which had burst into the mouth. The

polypi were thoroughly removed, and also the anterior end of the right middle turbinated body and the polypoid masses about the ostium maxillare were thoroughly curetted. The discharge continued profuse. Radical operation, as described by the speaker, was recommended and performed in St. Mary's Hospital on December 2nd, 1893. A two ounce bottlefull of polypi, granulations, and cholesteatomatous *débris* were removed. There was severe febrile reaction afterwards, which soon subsided, and patient left hospital in ten days, and gained in first week at home 7 lbs. in weight. The polypi recurred and the nasal suppuration continued, though clearly not from the antrum, as when the patient blew through the antrum from nose to mouth or *vice versâ* no pus was seen. Removal of polypi and bone and curettement of the ethmoidal lateral mass under cocaine were persisted in on and off until March, 1895, when the bone about the right frontal eminence appeared swollen, and the skin over it tinged with an erysipelatous blush the size of a shilling, together with considerable pain and malaise. He had been losing weight again, and there was evening pyrexia. Retention of pus was diagnosed in the right frontal sinus, and the left was possibly involved also, though in a less degree. There were both polypi and pus in the left nostril, which had been treated throughout the case; the antrum on this side was translucent. Operation was recommended, and the frontal sinuses were opened on March 23rd, 1895. The patient had a very deep natural median furrow on the brow, so this was used for a mid-line incision. A half-inch trephine was used and applied centrally, its progress being carefully tested with clean quills. As soon as the sinuses had been entered on either side the crown was levered up from its attachment to the septum between the sinuses and detached. At once a membranous sac containing gelatinous polypi and yellow pus sprang from each sinus into the wound. Both sinuses were now thoroughly curetted out, passages made freely into the nose with sharp spoons, the cavities swabbed out with chloride of zinc, and a rubber drainage-tube passed through each sinus out through the corresponding nostril, their ends tied loosely together, and the skin incision sewn up. Warm boracic irrigations were used both through the tubes and in the nose, and

the tubes were slightly moved each day, and were finally removed about the tenth day. The patient was shown to the Society on April 10th, and in the 'Proceedings,' vol. ii, page 74, is simply mentioned by name, as a case of antral empyema. The patient had gained eleven pounds in weight since the operation seven days previously, and there was hardly any discharge, while the skin wound had closed.

The patient was shown again at the annual meeting on January 8th, 1896, as an instance of a radical cure. There had been a gradual diminution of suppuration until it completely stopped, and no recurrence of it or the polypi had recurred for several months. The line of incision was almost invisible owing to the deep natural furrow.

During 1896 the patient entered the Army Medical Service and went to India on active work. He continued in the fullest enjoyment of health and energy till he injured his leg during prolonged riding on duty and developed phlebitis and thrombosis of the left saphena. On returning home in 1901 he was in St. Mary's Hospital. He then had not had any recurrence of polypus or nasal suppuration for over 5½ years. Unfortunately, however, the phlebitis in the leg persisted with relapses until, on October 3rd, he was considered to have recovered and to be fit to return to duty. He returned to London from the country with that view, when he was seized with cerebral thrombosis, from which he died in three days.

Dr. Spicer considered the interesting points about the case were its long duration, extensive diffusion, and obstinacy of the intra-nasal disease. Before coming under his charge irrigations only had been used, and removal of the larger polypi with forceps. He underwent constantly repeated operations at his hands for over 1½ years before the intra-nasal disease was finally eradicated, but in the end he was cured, and remained so for 5½ years, dying of a quite independent affection. Further, there was a remarkable gain in weight after each of the larger operations. Lastly, this was one of the first cases of cured frontal sinus empyema to be demonstrated at the Laryngological Society of London, and although the notes had not yet appeared in the 'Proceedings,' he thought they were of sufficient interest now the case is finally concluded.

A Case of Bony Thickening over and Polypi within the Right Frontal Sinus in a Man æt. 40; Operation; Recurrence of Bony Growth and Commencing Similar Symptoms on the Opposite Side of the Face.

Shown by Dr. Scanes Spicer. The patient was first seen on November 23rd, 1901. A month previously a swelling had appeared over right frontal eminence with pain; the upper eyelid was œdematous and the palpebral fissure almost closed. There was a long history of nasal catarrh. Trans-illumination of the sinuses showed the most marked relative blackness over the affected eyebrow, with unusual translucency elsewhere. Dr. Spicer diagnosed intra-sinus disease with retention of fluid and distension of the anterior wall, and recommended exploration of the sinus. This was done, and it was found that the bone was unusually dense and thick, and a large amount of the diffuse osteoma was chiselled and gouged away. On reaching the sinus it was found to be filled with polypoid tissue; there was no communication with the opposite side. The sinus was gently curetted and washed out into the nose without difficulty, and then packed with ribbon gauze, the end being brought out through the forehead wound and the latter sewn up. The gauze was removed on the fifth day, and the patient made an uninterrupted recovery and was about within the week. Later he returned with a new rounded bony swelling on the frontal bone on the same side, which was slightly tender, and on the left side the eyelid was œdematous, and the palpebral fissure almost closed, and there was some ill-defined thickening of the left supra-orbital ridge. He said he had knocked himself there accidentally a few weeks before. He was ordered iodide of potassium gr. v, t.d.s., and directed to show himself in the beginning of the year.

It appeared to Dr. Spicer to be an unusual case. There was no history of rheumatism, gout, or any constitutional disease which might throw any light on the case. At the present date he has been taking the iodide for two months, the bony swellings had diminished, and the eyelids and palpebral fissures were both quite normal as well as the intra-nasal condition. The rapid

diminution of symptoms under Pot. Iod. suggests "nodes" of a specific nature which, however, the extreme hardness of the bony tumour that was cut into would appear to negative, but opinions were invited as to the diagnosis of the case.

Specimen of Pharyngeal Lipoma.

Shown by Dr. Milligan. Mrs. H—, æt. 37, had suffered from her throat for from one to two years. She complained of slight dysphagia, a feeling of fulness in the throat and considerable amount of dyspnœa when lying down. Her general health had also depreciated and she had lost a certain amount of weight. On examination a large unilateral ovoid swelling was found under the mucous membrane of the posterior wall of the pharynx on the left side. The swelling extended upwards behind the level of the soft palate and downwards behind the larynx, where, indeed, the swelling was most prominent. To palpation the swelling appeared soft and doughy. There was no pain, no expectoration, and no temperature. Diagnosis lay between the possibility of a chronic abscess or lipomatous tumour. The fact that there was no indication of any bone disease present rather negatived the idea of abscess. The patient was put under chloroform with the intention of removing the growth through the mouth, but it was deemed advisable, owing to its size and to the dyspnœa from which she was suffering, during the chloroform anæsthesia, to make a lateral incision and remove the growth from the outside. This was accordingly done and the growth was successfully removed. The patient made an uninterrupted recovery, and was rapidly regaining her health and her strength.

The President thought it a very interesting specimen.

Dr. Jobson Horne thought it would considerably add to the value of the communication if Dr. Milligan would allow the Society to have a section of the specimen. As the specimen was in a bottle it was difficult to express an opinion as to its nature.

Microscopic Section of Fibro-Sarcoma of Right Vocal Cord.

Shown by Dr. Milligan. H. C—, male, æt. 61, had suffered from his throat for six months. He complained of slight pain upon the right side, accompanied by progressive loss of voice. There was no expectoration, no loss of weight, and no history of any previous illness of any moment. When first seen there was slight congestion of the right vocal cord, but no appearance of any growth. When seen six months later the right vocal cord was found to be deeply congested, almost immobile, and growing from its upper surface, at about the junction of the middle with its posterior thirds, there was a smooth rounded reddish-looking growth about the size of an ordinary red marble. There were no enlarged glands. The rapidity of the growth, the almost complete fixation of the vocal cord, and the age of the patient made it probable that the growth was malignant. Its contour and its want of ulceration suggested a sarcomatous process. Immediate operation was advised. In the first place a tracheotomy was performed, and three days later the larynx was split and the growth fully exposed. It was removed entirely along with a considerable amount of contiguous mucous membrane. An uninterrupted recovery ensued, and at the present time, now nearly twelve months since the operation, the patient was in excellent health and with no appearance of recurrence.

Microscopically the growth had the structure and characteristics of a fibro-sarcoma.

The following is the report from the Clinical Research Association:—"On the free surface the specimen submitted shows considerable activity, and has the structure of a sarcoma, composed in the main of spindle cells, but also showing round and branched cells. The central part of the tumour is composed of fairly well developed fibrous tissue. From the appearances presented I think the tumour should be regarded as a fibro-sarcoma. The epithelium covering the tumour shows active proliferation, and at one spot there is irregular down-growth. At this point it is a question whether some of the large cells seen are not to be regarded as epithelial." Mr. C. H. Wells

adds to this report: "I think, on the whole, that they should be regarded as derived from the connective tissues and not from the epithelium overlying them."

Dr. LAMBERT LACK suggested that both the above specimens should be referred to the Morbid Growths Committee. He thought there was considerable doubt as to the diagnosis in both cases.

Dr. MILLIGAN had not the least objection to the specimens being referred to the Morbid Growths Committee. With regard to the second, the piece shown was all he had, as the Clinical Research Association had not sent him back the remainder.

On the President putting the question to the Society, it was unanimously agreed to refer the two specimens—No. 5, specimen of lipoma of the pharynx, and No. 6, specimen of fibro-sarcoma of vocal cord—shown by Dr. Milligan to the Morbid Growths Committee for report and examination.

X-RAY PHOTOGRAPH SHOWING PLATE OF TEETH IMPACTED IN UPPER LARYNGEAL ORIFICE.

Shown by Dr. MILLIGAN. M. C—, female, æt. 32, swallowed her teeth during sleep, the place of impaction being doubtful. The X-ray photograph now exhibited was taken, from which it would be seen that the plate was lodged in the upper laryngeal orifice. By the help of a laryngoscope the plate was extracted, and the patient made a good recovery.

Dr. MILLIGAN also showed an X-ray photograph of a rubber tube which had slipped into the maxillary antrum in a case which had been operated upon for chronic maxillary antrum suppuration, and one of an ordinary Eustachian catheter passed into the frontal sinus of a patient suffering from chronic suppurative frontal sinusitis.

SPECIMENS OF PAPILLOMA OF THE TONSIL AND OF THE POSTERIOR PILLAR.

Shown by Dr. H. SHARMAN. The patient from whom these specimens were taken was a boy æt. 15, shown to the Society nearly four years ago, May 11th, 1898 (see p. 86 of vol. v of 'Proceedings').

He had a sessile papilloma of the left tonsil and a pedunculated papilloma of the left posterior pillar of the fauces.

After the patient had been shown the tonsils were removed and the pedunculated papilloma also.

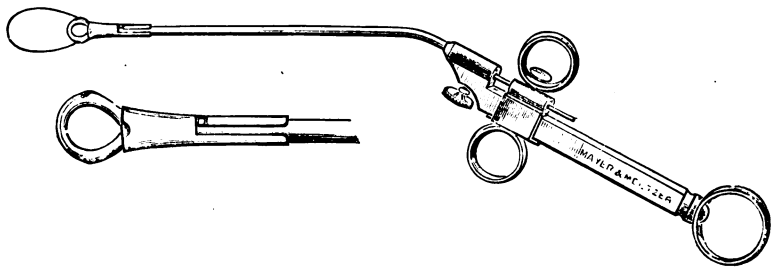
A section of the left tonsil through the papilloma was cut by Dr. Hewlett, and also a section through the papilloma of the posterior pillar. Both were true papillomata, with finger-like processes covered with stratified epithelium.

The interest of the specimens was that they showed that the papilloma of the tonsil grew from the *surface* of the tonsil proper (*not* from the interior of a lacuna), and that it apparently lay quite behind and unconnected with the expansion from the anterior pillar known as the "plica triangularis."

The slides have been presented to the Society.

A Self-Looping Nasal Polypus Snare.

Shown by Mr. Atwood Thorne. This snare was made by Messrs. Meyer and Meltzer, and consists of a Y-shaped end-piece fitted on to the usual Krause snare. The two upper ends of



the Y are joined by a slightly curved surface, and the polypus is caught between the wire and this surface.

The loop is tightened in the usual way by approximating the two finger plates. When the polypus is withdrawn from the nose by simply separating the finger plates, the loop is reformed without the usual fingering. As there is no knot or sharp twist in the wire, it has not the usual tendency to break.

In addition to its use for simple polypus, it is particularly adapted for the removal of moriform growths from the posterior end of the inferior turbinal, as the instrument can be passed with the loop retracted, and when in its right position the loop can be ejected, when it will take on any curve to which it has been previously bent.

The instrument can be used for the larynx as well as the nose.

Messrs. Meyer and Meltzer can supply the instrument complete or will make the addition to a Krause snare for a small sum.

Mr. BENNETT thought the instrument very ingenious, but doubted whether its practical application would be very useful. He used snares made on the same principle, though less perfectly finished than Dr. Thorne's snare. The objection was that a wire coiled round a large surface did not cut through if the tissues were at all thick, and then one had to tear the polypus off. In all tough growths this defect would be found a serious one, for in such cases one would have to use considerable traction.

Mr. ATWOOD THORNE had just heard that a similar device had been shown in Berlin about a year ago, but this was news to him. In the cases in which he had used it the results had been very good.

A CASE OF NASAL OBSTRUCTION IN A WOMAN ÆT. 24.

Shown by Dr. JOBSON HORNE. The patient had recently come under observation on account of symptoms attributed to nasal obstruction. The history was that some six or seven years previously she had suffered in a similar way, and had had the inferior turbinated bodies removed. An examination of the nose showed that the inferior meatus was very roomy, and there was evidence of a "spoke-shaving" operation having been performed, probably some years before. The middle turbinated bodies on both sides were hypertrophied and the middle meatus obstructed. The tonsils were somewhat enlarged, and there was hypertrophy of the adenoid tissue in the post-nasal space.

Dr. Jobson Horne brought the case forward with reference to two points. In the first place, the spacious inferior meatus with free expiration, and the occluded middle meatus with obstructed inspiration, supported the observations recently made by Mr.

Parker ('Journal of Laryngology, Rhinol., and Otol.,' vol. xvi, p. 345) on the directions of the air currents in the nose; namely, that the current of inspired air passed upwards and backwards through the middle and superior meatus, entirely missing the inferior meatus, and that the current of expired air passed chiefly through the inferior meatus.

In the second place, the hypertrophy of the mucous membrane covering the middle turbinated bodies raised the question whether such hypertrophy could be consequent upon the removal of the inferior turbinated bodies, for if so, whatever the immediate result might be from inferior turbinectomy with a view to reducing inspiratory obstruction, the ultimate result might be the reverse to that anticipated, and most disappointing.

Dr. HERBERT TILLEY was very interested in the case, because he believed the nasal obstruction to be due, not to any of the intra-nasal structures, but to collapse of the alæ nasi. On asking the patient to breathe without a speculum in the nostrils, the alæ nasi on inspiration were both sucked in, and on expiration a considerable noise was made. But directly a speculum was inserted the patient breathed quite easily and noiselessly. Under these circumstances he considered that to carry out any operative treatment inside the nose would be both unjustifiable and unscientific. The possible and probable explanation of the condition was that as a child the patient suffered from adenoids or some form of nasal obstruction, and as a result of disuse the soft parts at the entrance of the nostrils had not developed, with the result which was evident in the case exhibited.

Dr. BENNETT said there was another interpretation of the obstruction beside that given by Dr. Tilley. In most patients a sense of greater freedom was given when a speculum was inserted into the anterior nares. In this particular case the obstruction was not so much a real obstruction as a subjective obstruction. The patient stated that the right side was fairly free, but that the left side seemed blocked. Careful inspection showed that the anterior part of the left middle turbinal was in contact with the septum. Such contact often gives rise to a sense of obstruction. It can be cured by treatment which prevents this contact. In some cases this can be effected by the galvano-cautery, but the best method is to snare off a little of the redundant tissue on the inner side of the turbinal body. It is unnecessary to remove any bony tissue. He had come to the conclusion that it was very important in such cases to carefully distinguish between what might be termed objective and subjective obstruction.

Dr. SCANES SPICER was glad to hear Dr. Tilley's remarks in reference to the collapse of the alæ and the nasal vestibule as a factor in obstruction. He did not remember to have heard any special reference

at this Society's meetings made to this, and yet, in his opinion, a great deal could be done for that factor in many cases of obstruction. What was wanted in this case was to secure efficient action of the dilatatores alæ nasi so as to lift away the alæ on inspiration. In many cases this could be effected by conscious education of those muscles by assiduous practice. In some of these cases this was much facilitated by a good stretching of the soft tissues of the alæ nasi with a Hill's dilator. This should be followed up by systematic lubrication of the nostrils, and the wearing at night of a support such as the celluloid nasal springs, or little pieces of red rubber tubing of the largest calibre the nostril could accommodate and as shallow as possible. Physical exercises also were adopted, which had the object of re-establishing the normal co-ordinated action between the alæ muscles and the other inspiratory muscles. He had obtained markedly good results in many of his own cases, and he did not think this matter had been brought forward as prominently as its relative importance and efficiency demanded, though he had no doubt many members used these measures. It was, however, undoubtedly true that in a large proportion of cases the alar stenosis element was ignored.

Dr. Burt had seen a similar case, and did not think operative interference would be of any use. By putting in a tube to force the alæ nasi to work well, some relief might be given. It was the only way in which he had been able to give relief in a case of his own, where the inferior turbinate body had been removed for some obstruction and the alæ nasi had collapsed. He did not think for a moment from his experience that mechanical dilatation would give permanent relief, for if the dilator were removed the alæ would soon fall in again.

Dr. P. McBride asked Dr. Scanes Spicer in what way he thought that forcible dilatation of the alæ could possibly affect the collapse. As far as he understood the cause, the collapse was due to paresis and resulting flaccidity; how, then, could stretching of the alæ possibly permanently enlarge the opening? He absolutely failed to see how it could be done. He was quite aware that Moritz Schmidt had written on the subject, and had come to the conclusion, after considerable experience, that mechanical dilatation, as accomplished by wearing a Feldbausch dilator, made the patients more comfortable, but he was unable to see how forcible stretching could permanently affect a condition of this kind.

Dr. Scanes Spicer asked Dr. McBride what he desired to infer by the term *paralysis* in these cases.

Dr. McBride said there was a dilator nasi, and he presumed the term "paresis," as applied to these cases, stood for paresis of the dilator nasi. He asked if after these measures described by Dr. Spicer patency was restored. What was the permanent outcome?

Dr. Scanes Spicer could not admit a "paralysis" in the true sense from nerve lesion. He thought that from long continued disuse (1) the alar muscles were weakened and paretic; (2) that the soft tissues of the alæ were stiff, rigid, and often contracted, and that the weakened muscles were unable to drag out the stiff tissues, especially when the action of the inspiratory air current led to a fall of atmospheric pressure in the nose; then the external atmospheric pressure

drove in the alæ. He would therefore describe the condition as one of functional paresis of dilators from disuse, combined with a stiffness or rigidity of cellular tissues from disuse, similar to what occurred in an over-rested joint. He would therefore suggest, as an explanation of forcible stretching of the alæ, that the resistance against which the muscles worked was lessened, and they could overcome this lessened resistance in the same way that, after a stiff joint had been mobilised under anæsthesia, it could be moved after by its own muscles, and these could again recover good power by practice. It had happened to him several times that in the course of an operation under anæsthesia for complex intra- and post-nasal stenosis, he had ended up with dilating the alæ if collapsed and rigid, when immediately they began to resume their normal inspiratory rhythm, which was kept up afterwards by practice and tube supports.

Dr. McBeide thought it would be most interesting if Dr. Scanes Spicer would show to the Society a case in which there was a collapse and in which this "mechanical dilatation" treatment had been tried, so that they could see if it was cured by that method.

Dr. Pegler said that with regard to the question raised by Dr. Jobson Horne as to whether in this case the middle turbinates were compensatorily hypertrophied, he did not think that these bodies were liable to this change. Here there was no hypertrophy of the left middle turbinate, but the right one showed signs of disease.

Dr. Milligan asked if there were any observations in the literature of the subject on what the paresis of the dilators was really due to. Had any microscopic examination of the muscle been made? If there was really an atrophy of the muscle, dilatation such as described could not have any possible value. If the muscle was atrophied, and it was dilated, would not the cicatricial contraction tend to narrow still more the vestibule of the nose? He was not aware of any observations having been made on the subject, but it was certainly one which might with advantage be investigated.

Dr. Jobson Horne, in reply, said he was glad to have heard so many suggestions and remarks; at the same time, it was a little difficult for him to accept the theory put forward by Dr. Tilley, attributing the obstruction to collapse of the alæ nasi. Dr. Horne said he was of the same opinion as Dr. Bennett in that the respiratory obstruction was caused by enlargement of the middle turbinated bodies and consequent narrowing of the meatus. He had brought the case forward mainly with reference to the two points stated in his opening remarks, but inasmuch as the treatment had been discussed he would mention that the patient had shown signs of commencing myxœdema, and had been taking extract of thyroid gland with beneficial results and subsidence of nasal symptoms. The case was therefore of value in illustrating the advisability of looking further afield for a cause in some cases of nasal obstruction, and of not overlooking the possibility of commencing myxœdema. He had no intention of suggesting further surgical treatment of the nose.

Case of Herpes of the Palate.

Shown by Dr. H. Snell. The patient, a butcher æt. 40, had obviously been suffering from chronic laryngitis for the last three months. On December 25th he awoke with severe pain and feeling of choking in throat, which lasted badly for some hours. Since that time he had had pain in throat. When seen on January 4th there were several dark patches on the hard and soft palate (limited to right side), and on the right side of uvula there were two or three small, round, shallow ulcers. These appearances had now largely disappeared.

A Case of Syphilitic Laryngitis in a Man æt. 52.

Shown by Dr. Donelan. The case had been brought before the Society on a previous occasion, since which he had been energetically treated by anti-syphilitic remedies, but though there had been improvement during the first few weeks, latterly the ulceration appeared to be spreading. The fixation of the left vocal cord was more marked than before, and he thought there was now evidence of malignancy, but desired the opinion of members.

Mr. de Santi thought it would be advisable to remove a piece of the growth and examine it microscopically. He thought it of a malignant nature. It certainly seemed to him to have altered a good deal since he last saw the case, there being greater thickening, ulceration, and fixity. But to clear up the diagnosis, recourse should be had to the microscope, and the case dealt with accordingly.

Dr. Donelan would endeavour to carry out the suggestions made by Mr. de Santi.

Case of Very Extensive Destruction of the Interior of the Nose, due to Tubercular Ulceration, in a Woman æt. 31.

Shown by Mr. de Santi. The patient had been married seven years and had had one miscarriage. There was no history of acquired or congenital syphilis, and nothing to corroborate any such condition, except the state of the nose. For some four years

the woman had suffered from chest trouble and hæmoptysis, and for three years she had been suffering from disease of the nose and larynx. There were well-marked physical signs of phthisis in both lungs, abundant tubercle bacilli in the sputum, and the larynx showed tubercular disease with ulceration. The main point of interest in the case was the very extensive destruction of the nasal cavities; the whole of the bony and cartilaginous septum had disappeared, and the greater part also of the turbinals; there was consequently great external deformity, due to falling in of the bridge of the nose. There was still active ulceration going on in the nasal cavities and tubercular ulceration of the larynx.

Mr. de Santi had never seen such extensive destruction of the nasal cavities follow on tubercular infection, and although there was no doubt about the tubercular nature of the case he considered there was a strong suspicion that syphilis played some part in the causation, in fact, that the case was one of mixed infection. As bearing on this question of syphilis, one could see on looking at the pharynx that there was a fenestra in the posterior pillar of the fauces on the left side; this was suggestive of syphilitic ulceration. Treatment so far had been entirely of an anti-tubercular character, and had been fairly successful in keeping the lungs and larynx from a rapid advance of the disease. He, however, now proposed to try anti-specific treatment as well.

The PRESIDENT asked if the sphenoidal sinuses had been investigated. He understood there was no doubt as to the tuberculous nature of the case, but something else besides tuberculosis seemed required to produce the deformity, *e. g.* syphilis. Accessory sinus disease might also be present.

Dr. FITZGERALD POWELL thought the patient was undoubtedly suffering from tertiary syphilis. He thought that there was not any appearance typical of tuberculosis. In reply to Mr. de Santi he said he had looked into the larynx, which appeared to him (from what was necessarily a cursory examination) to be the seat of syphilitic disease. With regard to the nose, he was quite convinced that the extensive destruction of the soft tissues and bone was the result of syphilitic ulceration. The same remark applied to the large perforation in the faucial pillar. Notwithstanding the fact that tubercle bacilli had been found in the nose, and that there was said to be tubercular disease in the lungs, he maintained that the extensive destruction of the nasal tissues was due to syphilis. This case presented very different

appearances to cases of mixed disease he had observed, and some of which he had shown at a former meeting of this Society.

Mr. DE SANTI, in reply to the President, said he had not examined the sphenoidal sinuses. He adhered to his decision that the case was a tubercular condition; but he also considered it almost certain that a mixed infection of syphilis and tubercle existed, for he himself had never seen such extensive destruction of the interior of the nose from tubercular disease alone.

CASE OF ULCERATION OF THE NASAL SEPTUM WITH MARKED PAIN.

Shown by Dr. BENNETT. Miss H—, æt. 22, came first under observation in 1898. She was pale, tired, overworked, and suffering from frequent gastralgia.

The right nostril was obstructed. The septum of the nose was perforated, causing whistling respiration, and there was a good deal of tenacious muco-purulent secretion in the naso-pharynx. There was marked pain in the nose, and especially high up on the right side, where the tissues were considerably swollen.

The pain and swelling gradually increased. Incision of the swollen tissues and the application of ice during a period of several days did little good. Soothing antiseptic ointments, calomel fumigations, tonics, iodides, etc., were tried, but all without good result.

In July, 1898, the swelling became very great and the pain intense, so under ether some of the middle turbinal tissue was removed and the septum curetted. For a few weeks there was slight relief. The removed tissues were examined on more than one occasion, but no light was thrown on the cause of the ulceration.

During the last two years there had been gradual extension of the ulceration until nearly all the cartilaginous septum had been destroyed. There had been very frequent small and occasional severe hæmorrhages. The pain had apparently been very severe on one or other side, and often it had been accompanied by redness of the side of the nose. The swelling of the septum had been very great, and it must have attained a thickness of about one inch.

In March, 1901, she consulted Mr. Bond, who advised removal

of middle turbinal tissue so as to prevent the pain caused by the pressure of the swollen tissue. In June I removed more of the middle turbinals, and freely curetted the septal swelling.

Although there is relief as regards the nasal obstruction, the pain still remains as severe as before.

Dr. TILLEY said that the antra on both sides should be explored. From the right antrum at about the position of ostium, there was a small trail of yellow pus coming down. If there were pus in the antra, as he thought possible, he felt sure that their drainage would effect a considerable improvement in the condition of the nose. He had recently seen in consultation the case of a lady addicted to the cocaine habit, and who, under the influence of that drug, had picked away the whole of the cartilaginous septum, so that the combined nasal cavities were covered with a thin veneer of dried mucus and scabs producing an appearance identical with that showed by Dr. Bennett.

Dr. DUNDAS GRANT considered it a tuberculous condition of the septum. It might be lupus. It was too extensive for any form of simple perforating ulcer.

Dr. SCANES SPICER asked whether the ulceration *commenced* on the cartilage or on the bone. If the former he thought it was lupus, if the latter, syphilis. He had had a similar case, and showed it at the Society some three years ago. It had remained practically the same.

Dr. MILLIGAN thought it might be traumatic and the result of picking the nose followed by extensive ulceration. Was there any history to corroborate this view?

Dr. LAMBERT LACK suggested it might be a case of syphilis. He had never seen sinus suppuration cause a progressive destruction of the septum, whilst in cases of nasal syphilis, sinus suppuration was often seen.

Dr. BENNETT, in reply, said there was no disease of the ethmoidal or sphenoidal sinuses, and he should be astonished if the antra proved to be affected.

ERRATUM.

69th Ordinary Meeting.

Page 19, paragraph ii, line 2, *for* "lard" *read* "hard."

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-FIRST ORDINARY MEETING, *February 7th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.), JAMES DONELAN, M.B., } Secretaries.

Present—37 members and 3 visitors.

The minutes of the preceding meeting were read and confirmed.

The ballot was taken for the election of the following candidates, who were unanimously elected as Ordinary Members:

Arthur Roberts, F.R.C.S.Edin., M.R.C.S.Eng., Reading.
Herbert Elwin Harris, M.B., F.R.C.S., 13, Lansdown Place, Clifton.

The following report of the Morbid Growths Committee was read:

1. On Dr. MILLIGAN's case of fibro-sarcoma of the right vocal cord. Shown on January 10th, 1902.

"After examination of the specimen submitted, the Committee report that they can find no sufficient evidence upon which to base a diagnosis of fibro-sarcoma or malignant disease. The bulk of the growth consists of fibrous tissue. The Committee

suggest that the structures observed are the outcome of a slow inflammatory process."

2. On Dr. MILLIGAN'S case of pharyngeal lipoma. Shown on January 10th, 1902.

"The microscopic examination confirms the diagnosis."

The following cases and specimens were shown:

CASE OF TUBERCULOSIS OF THE LARYNX WITH MARKED SWELLING OF THE THYROID CARTILAGE IN A MAN ÆT. 37.

Shown by Mr. RICHARD LAKE. The patient had been sent into the Mount Vernon Hospital at the end of 1898, where he remained for three months, during which period at least forty pieces were removed from his larynx. The lung was only slightly affected, and, as far as physical examination went, this was entirely cured when the patient left the hospital. His larynx also was cured, and remained so for about eighteen months. During the latter half of 1901 he complained of occasional swelling of his thyroid cartilage; this, however, went down with a small amount of treatment, the interior of his larynx never showing any signs of recurrence.

He was not seen again until about three weeks ago. The condition was then much what was seen now: the thyroid cartilage was enormously thickened, was rather hard, and inclined to be uneven on its surface. Internally there was a pointed or conical projection forwards of the right ventricular band. He appeared to be more anæmic and thinner than he had been three months previously. His voice was much worse than it was; in fact, he could only make himself intelligible with great effort, which effort was accompanied by pain.

The case was brought before the Society for an expression of opinion as to the nature of, and best form of treatment for, the disease of the thyroid cartilage.

Dr. DUNDAS GRANT thought the condition looked like tuberculous perichondritis of the thyroid cartilage, but the progress was certainly rather slow. He had seen this in a case of laryngeal phthisis, eventually resulting in an abscess, but, if he recollected the case

aright, its course was much less indolent than that of Mr. Lake's case. As regards treatment, he suggested that the right course would be to open it, and having explored, to drain and inject with iodoform. It would be unfortunate if the whole thyroid cartilage were to come away as a sequestrum, since the obstruction following that would be very severe.

Mr. R. LAKE said he last saw this patient only a fortnight ago, and until then he had not seen the man for some time. The swelling was not then so extensive, but much harder. Four months ago when he saw him there was some temporary perichondrial trouble. He showed the case because he wanted suggestions as to what was to be done.

CASE OF RHINORRHŒA OF SOME YEARS' DURATION IN A WOMAN ÆT. 38.

Shown by Mr. L. A. LAWRENCE. The patient had had discharge of a clear fluid from the nose for many years. This followed an attack of general œdema at the age of 20, probably of acute renal origin.

The rhinorrhœa, from being occasional and fairly profuse, is now nearly constant, except when the patient has cold, during which time it stops almost entirely.

In 1895 she was seen several times by Dr. Edward Law, when the nose was fairly clear and dry at the back. Her sense of taste and of smell in those days was perfect.

Now she had largely lost these senses. Her nose on the right side showed deflection of the septum to the right, and some enlargement of the inferior turbinate bone, and a polypoid condition of the mucous membrane covering the middle turbinal.

On the left side the same sort of condition existed, but the turbinal swelling was more marked. The rhinorrhœa was more marked on the right side, and was excited by any kind of stimulus—draught, shutting a door suddenly, etc. Patient had a very large appetite, and slept abnormally well during an attack. She had had some vaso-motor disturbances about her fingers, and analgesia of thighs and hips and upper arms, which was more or less transient.

Local treatment for the nose had been tried—chromic acid and alkaline douches, and the cautery—without avail. Internal remedies—iron, arsenic, and strychnine—seemed to have done

more good; supra-renal extract had also been tried, but none of them had given any certain relief.

The PRESIDENT suggested in reference to the question of treatment that a trial might be given to the method he had employed in a case he had shown to the Society three or four years ago, where the rhinorrhœa was arrested by the application of the continuous current externally to the nose. He looked upon the condition as a vaso-motor neurosis.

Dr. HERBERT TILLEY thought the symptoms were the outcome of some obscure local vaso-motor neurosis, but that failure to give relief in this case should not be assumed until certain obvious pathological defects within the nose had been relieved. In the left middle meatus was a polypus the size of a horse-bean, and similar chronic inflammatory changes could be seen in the right nasal cavity, although the exact definition of such changes was obscured by a very prominent deflection of the septum towards the right side. It was highly probable that the removal of such obvious pathological changes would give at any rate partial relief to the symptoms.

Dr. H. LAMBERT LACK agreed with the last speaker as to the condition of the middle turbinates, and considered the case just one of those in which local disease in a neurotic subject was responsible for the rhinorrhœa. The same local conditions in another patient might not cause such symptoms. He thought that both middle turbinates should be partially removed.

Mr. F. H. WESTMACOTT said that the part which at first sight looked like a polypus, having a glazed translucent appearance, was, he thought, really due to some of the discharge having dried upon it. On looking carefully one might see a condition of lobulated hypertrophy of the middle turbinate bone. He had had a good many of these cases, and had been struck with the advantage accruing from removal of one or more of these protrusions of the mucous membrane and applying pure carbolic acid every day for about a fortnight. As carbolic acid was an anæsthetic, the application was painless, except for a little momentary smarting. Patients stated that the anæsthetic effect of the acid remained for quite twelve hours, and in some cases for twenty-four hours. He found this treatment effected a considerable diminution in the rhinorrhœa, and if, as in this case, the inferior turbinals were not so much affected, a good deal of improvement took place. As regards the mode of application, this was done by means of cotton wool wound round the end of a wire probe; the wool was dipped into the acid and then applied the whole way round the edge of the middle turbinate bone.

Dr. PEGLER said that no mention had been made of the deflection of the septum to the right side, which was a source of trouble in continually keeping up contact with the outer wall. The polypi of the middle turbinate might be attributed to the general sodden state of the mucous membrane. Glacial acetic acid would be a good application to try in this case, but the result was not reliable.

Dr. DUNDAS GRANT said that the correction of the septal deviation

either by straightening or by removing a projecting part would be very advisable for the purpose of manipulation of the deeper parts of the nose. He did not think it likely that the septal deflection was directly one of the elements in the production of the trouble. The attacks of so-called cold seemed to be almost daily, and answered very much to the description of hyperæsthetic rhinitis. He asked whether adrenalin had been tried.

Dr. FitzGerald Powell was of opinion that this case represented what was understood as hypertrophic rhinitis. The middle turbinate was enlarged, and the inferior turbinal slightly so, and there was a distinct spur on the septum. He thought that the only chance of getting much relief would be to remove in some way portions of the middle turbinate, either by shaving them off or by the use of the cautery. Local application of washes, etc., in his opinion, would have no effect until the abnormal portions referred to were removed.

Mr. L. A. Lawrence said that adrenalin had been tried, but without benefit. He was much obliged for all the suggestions that had been made, but they were all offered with the idea of relieving the nasal obstruction. With regard to that, he supposed that most of them would agree that the nasal obstruction should be removed, but was the nasal obstruction the cause of the rhinorrhœa? That was the important point. Many people had a deflected septum, or an enlarged turbinate, or polypoid masses, but they did not suffer from rhinorrhœa as a consequence. The patient was of an extremely neurotic tendency. He was afraid if he followed all the advice given there would not be much left of the interior of the nose. He wanted to hear if there was any experience of cases of this nature having been treated otherwise than by removal of obstructions and portions of the turbinates, etc., and would welcome any suggestions of that sort.

Case of Lupus Nasi.

Shown by Mr. F. G. Harvey. The patient, a man æt. 24, had suffered from an obstruction to breathing in the right side of the nose ten years ago. A swollen condition of the right inferior turbinal was noticed at that time, and the disease had since successively implicated the skin of the tip of the nose, the posterior choana and pharyngeal roof on the right side, and the epiglottis. The region of the inferior turbinal and the skin of the nose had been cured by the use of the curette, but the disease remained active in the roof of the naso-pharynx.

Mr. Parker said that this case had been under his care for many years. He first saw the patient in 1894, when he came to the hospital suffering from nasal obstruction of three years' duration. There was apparently, then, an ordinary hypertrophic outgrowth from

the inferior turbinal. This was removed. Instead of healing the wound became ulcerated, and assumed the characteristics of a tuberculous ulcer. The chest was then examined, and well-marked signs of phthisis discovered. It was an interesting point as to whether the outgrowth originally removed was a tuberculoma or whether it was hypertrophic, and whether, if the latter, the resulting wound had been infected from the lungs. The ulceration had extended and affected the pharynx, and in May, 1895,* the case was shown here as one of "tubercular ulceration of the nose and pharynx." After this date the patient developed typical lupus in the skin of the nose, and a little later the epiglottis became affected. Meanwhile the condition of the lungs improved, and then became quiescent. Whilst under his care Mr. Parker had tried both local and general treatment, but the only thing which did him any real good was a very severe attack of erysipelas, after which he was very much better for a long time. The speaker had last seen the case about three years ago, and he thought the present condition was very much as it was then.

Case of Partial Membranous Occlusion of the Right Posterior Choana.

Shown by Dr. Lambert Lack. The boy, æt. 18, had thin crescentic bands passing from the roof of the naso-pharynx down towards the base of the nasal septum attached along the outer side of the space, almost completely hiding the choana on the right side, and less prominent on the left side. There was a small perforation of the septum, and the boy said he had had a discharge of thick matter from the nose some years ago, but no reliable history could be obtained.

The President had made a careful examination, but did not think the partial occlusion was on the choana itself, but behind it. It was a band extending up from the Eustachian cushion, and looked like a cicatrix, but he was unable to obtain any history of an operation. There was also perforation of the septum.

Dr. Scanes Spicer agreed with the President as to the membrane being posterior to the choana and in the naso-pharynx; the band extended upwards from the right Eustachian cushion to the adenoid tissue at the apex of the right choana, and it had the appearance of a cicatricial band, as frequently seen here.

Dr. Dundas Grant thought the case presented a great many points of interest, and it would be valuable if Dr. Lack would describe the history more thoroughly. The patient said that at one time a mass of some sort came away from the back of the throat. It was crumbly in consistence. After that he was able to breathe

* See 'Proceedings,' vol. ii, p. 83.

through the nostrils, although previously he was unable to do so owing to the great obstruction. He thought that these partial web-formations were cicatricial, but felt some difficulty in surmising as to what it was which had come away. It might be simply some inspissated cholesteatomatous matter, which was sometimes seen in the nose, or it might be a soft rhinolith or a sequestrum. From the deformity of the part he thought it quite possible that a small sequestrum had come away.

Mr. SPENCER thought the diagnosis turned on the question of the septal perforation. The cicatrix seemed rather far back to have been the seat of operative interference. The perforation was probably due to inherited syphilis. Perhaps a sequestrum had come away, which would explain the history given. There also had to be taken into account the facial aspect and the eye symptoms.

Dr. STCLAIR THOMSON thought he could throw some light on the perforation of the septum. He inquired of the man if he had had an operation performed. He had. The patient had performed it himself! He had in his pocket a horse-nail, which he had once pushed up his nose. Dr. Thomson felt so sure on examining the cicatrix that it was traumatic in origin that, when there was no history of any operation by a surgeon, he cross-questioned the man with the result stated. When he once had some nasal obstruction the man pushed the nail up to relieve the obstruction; he then felt something come away; this was followed by profuse hæmorrhage. From the appearance and the situation of the perforation, which was not in the bony septum, but at the back of the cartilaginous part, he thought the patient's own explanation was a very probable one. He would like to hear from Dr. Lack if he had put his finger into the choana, because he (Dr. Thomson) could not say from inspection of the case that it agreed with the description of "membranous occlusion." It was situated entirely on a posterior plane, and there was a somewhat similar condition on the other side. The occlusion really extended from the cushion of the Eustachian tube up to the roof of the pharynx. Such an occlusion was not uncommonly left by adenoid remains.

Dr. FITZGERALD POWELL said it would be rather interesting to get a portion of the band away and have it examined under the microscope to make out the exact construction of the tissue. It might be, as suggested, cicatricial tissue, but it was difficult to explain exactly how it came to exist there. Whether it was a developmental growth and had always been there or whether it was a growth of adenoid tissue arising in the fossa of Rösenmuller which had become attached to the cushion of the Eustachian tube was doubtful. If there had been nasal obstruction, and this was cleared up by something coming away, it was probably a large crust.

Mr. SPENCER doubted whether it was possible for the patient to have pushed such a nail through a healthy septum. To have done so there must have been previous ulceration or softening. He probably pushed away a crust or sequestrum which was obstructing the nasal passage.

Mr. WESTMACOTT thought that a man could easily injure the

septum with a nail of that size. It was well known how easily an ulceration in the septum following traumatism did spread through to the other side and leave a typical perforation such as they had now before their notice.

Dr. H. Lambert Lack, in reply, regretted that the history was incomplete and unreliable. He should say that the mass which was said to come from the post-nasal space was probably a sequestrum. He had put his finger into the space and had found a very definite band with a concentric margin, which was quite different to anything he had ever felt before in the adhesions which occurred in a man with adenoids. He did not think it was due to adenoid growth, but more likely to congenital syphilis.

Case of Œdema of the Larynx for Diagnosis.

Shown by Dr. Lambert Lack. The patient, a man æt. 40, had been in the London Hospital for three months suffering from hoarseness and slight dyspnœa. The voice had been affected now for nearly six months. There was no difficulty in swallowing and very little expectoration. There was some wasting, but the patient felt well and strong. There were no physical signs of phthisis, and no tubercle bacilli had been detected in the sputum.

On examining the larynx the right arytænoid region was seen to be an immense œdematous swelling, smooth and not ulcerated. The œdema extended slightly to the right side of the epiglottis. The left arytænoid appeared normal, but was partly hidden by the swelling on the right side. The interior of the larynx could not be seen.

Mr. W. G. Spencer thought the diagnosis of this case very interesting. It looked almost as if it were a malignant condition, but there were no glands in the neck, and in epithelioma in that particular region the glands in the neck were so early enlarged; in fact, very often the glandular enlargement preceded the discovery of primary epithelioma. The disease could not very well be tuberculous owing to the length of the history and the absence of glands in the neck. He was therefore of the opinion that it must be of syphilitic origin.

Dr. StClair Thomson had shown a very similar case to the Society about a year ago. It ran a very erratic course. Several members thought it might be malignant. He watched the patient and had to perform tracheotomy later on. Very soon afterwards the patient's health broke down, and he died of tuberculosis, bacilli having been

found previously. Dr. Horne had possession of the larynx. The post-mortem examination was confirmed by sections.

Dr. H. Lambert Lack said he brought the case forward because he could not arrive at a diagnosis. The case had been thoroughly treated with iodide of potassium and mercury, and he had been kept in bed in hospital for three months. There were no tubercle bacilli, and further, if the case had been tubercular in nature, it would probably have got markedly worse under iodides. The man was wasting. He did not know if sarcoma was a possible diagnosis, but it might have to be taken into account.

Case of (?) Syphilitic Ulceration of Soft Palate occurring during a Course of Antisyphilitic Treatment.

Shown by Mr. Atwood Thorne. The patient, a man æt. 23, contracted syphilis in May, 1901, since when he had been treated with mercury, and latterly with mercury and potassium iodide by the mouth. After eight months' continuous treatment he was found to have deep ulcers on the soft palate, and despite active local treatment with silver nitrate the patient had got worse and lost his uvula and a part of the soft palate; he looked exceedingly ill and was very feeble. He complained that he had lost a great deal of flesh, and had some difficulty in swallowing. On examining the throat, the uvula and part of the soft palate adjacent to it were now missing, the edge of the remaining portion being covered with a dirty white slough, and on the posterior wall of the pharynx and on the posterior edge of the septum nasi there was a yellowish thickened exudate. Crepitations were heard at both apices, but no tubercle bacilli could be found in the sputum. Antisyphilitic remedies had been stopped, and every endeavour made to feed up and strengthen the patient.

Mr. Thorne asked for the opinions of the members on the nature of the case; personally he took it to be at any rate due partly to syphilis, but was surprised that the condition should commence while the patient was being actively treated for syphilis.

Dr. StClair Thomson would like to hear again what treatment the man was having. He looked very cachectic, and as if he would not stand very much. He regarded the case as one of syphilis only.

Dr. Dundas Grant thought there was a tubercular element in

this case. They knew that occasionally in secondary syphilis ulceration and destructive lesions occurred, but they were very uncommon. The very extreme ulceration occurring so soon in the course of the disease, together with the general characteristics of the patient, made one ask if there were any further evidence of tuberculosis.

Mr. SPENCER said it might be a "mixed" case of tubercular-syphilitic infection. If the iodide were continued the man would certainly die. He recommended keeping the patient in bed and putting him on the "tonic" treatment; very little mercury should be given.

Mr. R. LAKE thought it was a perfectly straightforward case of syphilis without any question of tuberculosis. He did not think twelve months so very short a period for even such extensive lesions as were present in this case, for ulceration might commence early and be followed by severe destruction of tissue when a case was going to be really severe.

Dr. LAMBERT LACK agreed with the previous speaker's remarks. It was purely a case of syphilis, and if the man were treated by being put to bed and fed on plenty of milk and eggs, with a little anti-syphilitic treatment, in a month he would be practically well.

Dr. FITZGERALD POWELL thought that large doses of iron and strychnine were very necessary in such a case as this. He had found that iodide of potassium and mercury in cases where a man was in an anæmic condition were worse than useless. If it were possible he would send this man to the seaside, and as he improved in health, in addition to the iron and strychnine, he would give him just a little iodide of potassium and mercury; under this treatment he would soon get better.

Mr. ATWOOD THORNE, in reply, said that on examining the chest, he found distinct evidence of phthisis, but there were no bacilli in the sputum. While the man had the chancre, he was put on mercury, but during the last month a small amount of iodide had been added. He thought it was a mixed case and would feed the man up and give him small doses of iodide and mercury.

CASE OF MYELOMA OF THE NOSE IN A WOMAN ÆT. 30.

Shown by Mr. WAGGETT. The patient, previously quite healthy, began to notice nasal obstruction in June, 1901, three months after confinement. Obstruction increased until, at the time of her first visit, in October, the right side had become completely blocked, and epistaxis was frequent.

On examination the right nostril was found to be filled by a large dark red growth, with an intact smooth surface, feeling elastic to the touch, and bleeding readily. The right eye was more prominent than the left. Under an anæsthetic the large

tumour, which completely filled the nose, was removed piecemeal and without serious hæmorrhage. The tissue was dark in colour, of firm consistence, and contained a sponge-work of bony trabeculæ.

Microscopic examination showed the structure to be typical of myeloma, containing numerous giant-cells (specimen exhibited). During the operation it was found that the growth had created a smooth-walled pressure cavity encroaching upon the orbit. Proptosis disappeared within two days of operation. In consequence of the microscopical diagnosis of tumour of only a local malignancy, a more radical operation was undertaken a few days later.

The seat of origin of the growth seemed to be in the region of the middle turbinate or of the unciform process. Rouge's operation was therefore performed, the anterior wall of the antrum and part of the septum were cut away, and the greater part of the inner wall of the antrum and of the inner wall of the orbit was removed.

The exact anatomy of the parts, deformed by encroachment of the tumour and obscured by free hæmorrhage, could not be determined, but apparently a thorough removal was made of all suspicious tissue. Free access could not be obtained until laryngotomy had been performed and the gag removed from the mouth. Apart from the effects of orbital hæmorrhage the patient did not suffer much from the operation, and healing took place within the nose very rapidly. This process was accompanied by so marked and rapid a diminution in the size of the cavity that suspicion was aroused that the restriction was due not merely to cicatrisation, but to recurrence of the growth. Opinions were invited upon this question. Against the diagnosis of recurrence were the healthy appearance of the mucous membrane, the absence of epistaxis and want of any noticeable change during the last six weeks. The operation was performed early in November. The general health was excellent and pain absent.

Mr. W. G. Spencer would not say that the growth had recurred, he would wait till it bled continuously, for these tumours were very vascular. The nose required to be kept very clean as in atrophic rhinitis.

Dr. H. Lambert Lack asked if the nose was still gradually closing, because if that were so it might be due to recurrence. He did not think it would be possible to do any more if a recurrence took place.

Mr. E. B. Waggett said, in reply to Dr. Lack, that he thought the contraction took place during the first month, and that it was not contracting now. Three months had now elapsed since the operation. The contraction was especially noticeable in the region of the right choana where the septum seemed to pass away into the outer wall of the nose, which was precisely the part not affected, so that he was in hopes that the structures were cicatricial and not evidences of regrowth.

Tertiary Syphilis of the Pharynx and Larynx; Phonation with the Ventricular Bands.

Shown by Dr. H. J. Davis. The patient, a groom æt. 31, had laryngeal ulceration when the subject of secondary syphilis three years ago. He was admitted into the Middlesex Hospital two years ago for urgent dyspnœa, the swelling of the right ventricular band being so great as to almost occlude the glottis. Ulceration followed and stenosis had resulted.

His present condition showed ulceration of palate, which had a peculiar worm-eaten appearance, fixation of the true cords, phonation being accomplished by the ventricular bands.

Laryngeal Tuberculosis, with Granulation Tissue between the Cords.

Shown by Dr. H. J. Davis. The patient, a woman æt. 25, had pulmonary tuberculosis in the quiescent stage, and well-marked signs of the same disease in the larynx. She had lately undergone an open-air treatment, and had benefited materially.

At present, where there had originally been ulceration, a granulating mass extended downwards between the cords, which were thickened and fringed with granulations. On phonation the cords encountered the obstruction, the muscles failed to overcome it, and the cords quivered and then sprang apart.

The voice varied from a deep croak to a mere whisper, but the

patient stated that in wet weather the voice was always improved. Pallor of the palate was well marked.

Dr. JOBSON HORNE said the appearance of the larynx in this case was interesting and rather unusual. The tissue between the cords was described as granulation, but he would like to ask whether any member might feel disposed to speak of it as a tuberculoma.

Dr. H. J. DAVIS said there had previously been ulceration in the same position, and lactic acid had been rubbed in, but during the time the woman had been away undergoing the open-air treatment granulation tissue had grown on the surface of the ulcer.

CASE OF ABEYANCE OF NASAL BREATHING IN A FEMALE ÆT. 23; NASAL PASSAGES FREE; HYSTERICAL APHONIA; RHINALGIA.

Shown by Dr. PEGLER. The patient had been shown in 1899 for functional aphonia and recurrent apsithyria, which still persisted. Soon after that occasion she had developed mouth breathing, and her speech, though aphonic, became "clipped," a defect known as *Rhinolalia clausa*. There being a pad of adenoids and considerable turbinal hypertrophy in both chambers, these impediments to nasal breathing had been radically eliminated, but instead of the patient gaining any benefit, the above-named symptoms grew worse, and so they remained. Rhinalgia had been much complained of, especially recently; the mouth was always open, and the breath was peculiarly disagreeable, possibly owing to this fact. Before speaking, with a view, perhaps, to getting some use of her nose, she made a clicking kind of sound with her palate. The velum, on inspection, appeared paretic, but the exhibitor had no hypothesis to offer, especially in the light thrown upon this case by the next one, except that the nasal breathing and resonance were shut off by spasmodic contraction of the soft palate.

The photograph marked 1 showed this patient before her various hysterical symptoms set in, and when she was teaching in a school; the mouth was closed, and the expression highly intelligent. No. 2 photograph had been taken recently, and showed a very marked deterioration in this respect, with open mouth and dilated alæ nasi.

The PRESIDENT thought it a "hysterical" case. One had seen such cases, in which people occasionally talked without using their noses although there was no obstruction, and were unable to pronounce "m" and "n," and converted these letters into "b" and "d." He put down similar cases he had seen to neurosis of the palate. Dr. Pegler thought that in his case there was a spasm of the palate, but whether that was proved or not he was not aware.

Dr. SCANES SPICER thought this case a very important one. Dr. Pegler had quite satisfied him personally that there was now no organic obstruction, and yet, when the mouth was closed, no air entered on the patient attempting to inspire. After a time, unable to do without air any longer, she opened the mouth and violently inspired. The explanation appeared to be a functional spasm of the soft palate and pharynx—a hysterical contraction at a time when normally there should be a relaxation or yielding to the incoming air-current. It might otherwise be regarded as a hysterical holding of the breath by the soft palate. There was evidence of hysteria in the adductor laryngeal paralysis, so that apparently there was in this palatal spasm another instance of perverted respiratory rhythm parallel to what was occasionally seen in the larynx in hysterical subjects. The case demonstrated without doubt the abeyance of nasal respiration without any organic obstruction in the nasal passages to compel such abeyance. He thought the patient would be benefited by treatment of the causes of obstruction he had pointed out. Perhaps stretching the soft tissues of the alæ, followed by the use of rubber dilators at night, and education of the dilator muscles, would be ample. As to the soft palate in this case, he thought it was paretic rather than spastic.

Mr. WAGGETT suggested that the woman should be treated like a hysterical person with aphonia, namely, by forcing her to breathe through her nose by shutting the mouth and tying it up.

Dr. FITZGERALD POWELL said that as the patient could blow out a spirit lamp held under the nose whilst her mouth was closed, there could be no real obstruction. Apparently the soft palate seemed to suffer from some neurosis just in the same way as the cords suffer from neurosis in functional aphonia. There was a greater or less degree of post-nasal catarrh with a good deal of mucus coming down from behind, and probably the palate was in a more or less rigid condition. He hoped to be able to show a similar case at a future meeting suffering from functional obstruction to the breathing. The nose had been cleared of all objective causes of obstruction, but nevertheless the breathing had become worse.

Dr. WILLIAM HILL thought that in this case there was a want of co-ordination between nasal inspiration and the muscular actions of the palate and pharynx.

Mr. ATWOOD THORNE said that as the patient had a good current of air up and down both nostrils, he would advise breathing exercises with a forcibly closed mouth, and the usual general treatment for hysteria.

Dr. DUNDAS GRANT said that in this case there was a condition of

anæsthesia; as the patient did not feel the air which passed through the nose, she therefore did not think it did pass.

Dr. JOBSON HORNE inquired whether the possibility of tuberculosis had been entirely excluded as a factor in the aphonia.

Dr. PEGLER agreed with Dr. Hill, and thought the term hysterical inco-ordination of the muscles of the soft palate and pharynx would supply what was wanted in that regard. It was remarkable that since the nasal operations the symptoms had been aggravated; this might be due to the influence of auto-suggestion.

CASE OF ABEYANCE OF NASAL BREATHING, THE PASSAGES BEING FREE, PALATE AND FAUCES HYPERÆSTHETIC.

Shown by Dr. PEGLER. A. G—, æt. 31, came to the Metropolitan Ear, Nose, and Throat Hospital a few days ago complaining of her speech. ("Her bother said there bust be subthig the batter with her throat because she always spoke through her dose.") Patient dated the defect from November last, when she was sent to the North-Eastern Hospital as a case of supposed diphtheria. On her return she states that in drinking fluids returned through her nose. Dr. Cuff, however, assured the exhibitor that the case was one of tonsillitis only, and that three separate cultures failed to disclose any Klebs-Loeffler bacilli.

The mouth is kept open constantly. Examination of the nose and naso-pharynx gives a negative result in so far as explaining the total absence of nasal breathing and resonance were concerned. The pharynx was so irritable that repeated cocainisation was necessary in order to gain a satisfactory inspection of the post-nasal space. There was no nasal anæsthesia, but pain was complained of over the bridge. There was paræsthesia of the pharynx in the form of a pricking sensation in the throat, and the patient was constantly "clicking" and "hemming." Following the suggestions made in Dr. Lermoyez's paper on a similar case, Dr. Pegler closed the patient's mouth with his hand, when she held her breath till cyanosis set in, but after a violent effort the patient respired through the nose. Suspecting that palatal spasm was operating here as in the last case, Lermoyez's other experiment was tried, and the palate tied up by a tape passed through the nose, naso-pharynx, and mouth, the two ends being secured over the upper lip. After a slight effort the patient

breathed comfortably through the nose, her mouth being closed. The (moral) effect of this treatment was permanent, for the speech defect was now nearly absent. The photograph marked A shows this patient prior to her throat attack; the mouth is closed and the features natural. B shows the patient taken previous to treatment the other day, and is in obvious contrast to the former one.

Dr. Scanes Spicer took exception to Dr. Pegler describing the air-passages in this case as being entirely free, since insufficiency was proved by marked collapse of right ala on inspiration. There were three objective causes of obstruction: (1) the right nostril was a slit, and the ala collapsed on that side on attempting inspiration; (2) the septum was deflected, the deviation being sigmoid; (3) there was enlargement of the right middle turbinate with dry crusts. Certainly this case could not be placed in the same category as the previous one.

Dr. Vinrace said that regarding the doubt as to whether this patient had had diphtheria, he would like to point out that the regurgitation of fluids through the nose after the attack was, to his mind, stronger evidence in favour of diphtheria than the failure to find bacilli was against it. He would like to know whether this condition was or was not the result of diphtheria.

In reply to Dr. Vinrace, Dr. Pegler said he was content to accept Dr. Cuff's assurance with regard to the absence of diphtheria, besides which no point was made supposing the disease had existed; there might have been a paretic palate in the first instance, but the speech and breathing defect pointed to the opposite condition of spasm.

Dr. Vinrace remarked that if one searched for the bacillus and failed to find it, it did not follow that the patient had not had diphtheria.

Dr. Pegler, replying to Dr. Scanes Spicer, said he was sorry that he could not persuade that gentleman to regard the case in the same light as he did. The unilateral insufficiency was not of a kind that he should treat by operation, seeing that an armed probe passed comfortably through the narrower chamber, whereas in the companion one he was able to discern the pharyngeal wall easily without the aid of cocaine. As in the previous case, he looked to the vagaries of the tensor and levator palati muscles for an explanation of the phenomena, and thought the simple experiment of tying up the palate was conclusive in its result. Kyle alluded in his book to spasmodic affections of the palate, and in this case there were other evidences of choreic or spasmodic action in the upper air-passages. The inspection of the larynx showed contraction of the ventricular bands on phonation, which perhaps explained the hoarseness of the voice.

Case of Progressive Ulceration of the Nose.

Shown at the last meeting by Dr. Bennett. It had been suggested at the last meeting that the ulceration of the septum might have been due to antral suppuration. Dr. Bennett had therefore explored, but found no discharge.

Case of Œdema of the Larynx with Thickening of Palate, Uvula, and Fauces in a Boy æt. 10.

Shown by Mr. F. Hunter Tod. This case was under the care of Dr. Percy Kidd at the London Hospital. The boy's mother had noticed that for two years he had breathed through his mouth, and was very noisy in his sleep. Between October and December, 1900, he had had four operations on the tonsils and the back of the throat, but without relief. There had been wasting and day and night sweats, and difficulty in breathing at night.

At the present time the patient was thin, pale, and pigeon-chested. There was slight bronchitis, but no signs of pulmonary phthisis. The temperature was normal. No bacilli had been found in the sputum. There were no signs of congenital syphilis. There was laryngeal stridor, which was much worse at night, accompanied by retraction of the chest, but cyanosis had never occurred. Examination of the larynx showed enormous enlargement of the epiglottis, which was smooth and of a pale colour, and prevented a view of the interior of the larynx being seen. The tips of the arytænoids could be seen, both, but especially the left which seemed fixed in the middle line, being pale and much swollen. No ulceration was visible. The condition had remained unchanged since admission to the hospital four weeks ago. The uvula was much enlarged and œdematous, and there was considerable thickening of the palate and fauces. Mr. Tod suggested that the diagnosis rested between tubercular laryngitis and congenital syphilis, and that the patient should be fed well and given antisyphilitic treatment, and that tracheotomy should be performed if it should become necessary.

The PRESIDENT said the condition reminded him of congenital syphilis.

Mr. SPENCER said this was an interesting case, but he did not know what its origin was. There was some danger of his dying of suffocation suddenly one night. Something ought to be done to avoid this; for instance, tracheotomy combined with rest for a time, and careful treatment on the same lines as those proposed by Hunter Mackenzie for laryngeal growths in children. One might, in addition, remove the tonsils, and the lower pharynx, including the epiglottis, might be lightly scarified, and astringents rubbed in or cauterised.

Dr. DUNDAS GRANT asked if any albumin had been found in the urine. He had shown a case (March, 1897) to the Society of a boy who had had scarlet fever, with subsequent albuminuria, in which the œdema persisted very much as it had done in Mr. Tod's case, although he had some suspicion that the boy was the subject of inherited syphilis. He asked whether tuberculosis had been excluded in Mr. Tod's case. Tuberculin might afford information in a case of great doubt.

Dr. POWELL considered it a case of hereditary tertiary syphilitic infiltration, and would like to hear if the boy had been put on anti-syphilitic treatment. If not, he suggested that the boy's general health should be attended to by tonics, and that then antisyphilitic treatment should be employed. If there was any danger of laryngeal spasm tracheotomy ought, of course, to be done. At present there did not seem to be any spasm.

Mr. LAKE said he would give the boy Hyd. c. Cretâ.

Mr. HUNTER TOD said that Dr. Percy Kidd was inclined to think that it was a case of tubercular laryngitis, although there was no sign of pulmonary phthisis nor tubercle bacilli in the sputum. He had not been put on antisyphilitic treatment because he wished to see the effect of good diet and tonics. On admission there was so much laryngeal obstruction that tracheotomy was nearly performed, but at present there was no danger of suffocation as the boy could sit up all day quietly, and could sleep all night in the recumbent position.

ETHMOIDAL SUPPURATION IN A MAN COMPLAINING OF EXCESSIVE PAIN.

Shown by Mr. WAGGETT. The patient had been under treatment for some years. The greater part of the ethmoidal cell region had from time to time been removed. Both frontal sinuses had been opened and found healthy. Very severe frontal and vertical pain was complained of, and suggestions for treatment were asked for. A marked neuropathic element was present.

Dr. VINRACE wished to know what were the indications for the operative treatment of the frontal sinuses which had been resorted to twice in this case, and what were the beneficial results which were claimed after each of these two operations. Further he did not see why the left side had been interfered with when it was the right side on which there was the nasal obstruction. In the first instance it seemed that vertical headache was the prominent symptom, and in the second instance there was supra-orbital pain on the left side; and subsequent to the second operation, new symptoms had been introduced, and he would like to know if these were to be attributed to the second operation. As far as he could ascertain the sight had been affected and the patient was very giddy. It was very gratifying to him to hear of such good results following these operations, but the perplexing point was that, according to the account of the patient, when the first operation was done, the only pain he had was that of vertical headache, there being an absence of symptoms in the region of the frontal sinuses.

Dr. LAMBERT LACK thought the man had now had sufficient done to the nose, and the results of the operations were good. The man was now suffering from neurasthenia.

Dr. JOBSON HORNE said that this man was under his care for some few weeks after being under the care of Mr. Waggett, but he could find no sufficient cause for operating, and he thought that was the reason why the patient left him. The patient seemed to attach too much importance to his symptoms, and he advised him to undergo no further treatment for a while.

Dr. FITZGERALD POWELL said that this man had also visited him. He came to him after leaving Mr. Waggett, but he had only seen the man once; he did not recommend active enough measures. It was evident that there must be some considerable amount of pain in the frontal sinuses or forehead, whatever might be the cause of it, or he would not be so persistent in complaining of it. He suggested to Mr. Waggett putting in a seton, as in some cases frontal headache had been considerably relieved thereby. If the patient had remained under his care, he would have put in the back of the neck an ordinary tape, which might have had the effect of removing the pain to some extent. He would like to hear whether the frontal sinuses had been obliterated by operation.

Mr. F. H. WESTMACOTT asked whether it was not an experience quite commonly found after operation in cases of frontal sinus disease that the patient did very well for a time; the discharge ceased and the patient became apparently well. But after a time there was a periodical recurrence of the symptoms as regards the pain, etc., and yet on looking into the nose there was nothing, or very little, to account for the recurrence. In one or two such cases he had given considerable relief by simply passing up a cannula into the infundibulum and inflating the frontal sinus, after which the pain went away instantly. If in two or three weeks the patients again complained of their pain he repeated the process and with the same temporary success. He had come to look upon this state of affairs as very largely due to neurotic causes. There might be some foundation for the pain no doubt in local congestion.

Mr. WAGGETT said that this man had in the first place ethmoidal suppuration, and in the second place he was undoubtedly a hypochondriac of the worst type. He had treated him according to the rules of rhinology, with the exception that he had not yet explored the sphenoidal sinuses. The frontal sinuses were explored as severe frontal pain and tenderness were experienced, and the ethmoidal cells in the neighbourhood were suppurating.

CASE OF SUBJECTIVE NASAL OBSTRUCTION.

Shown by Dr. DUNDAS GRANT. Miss E. E—, æt. 34, was first seen by Dr. Dundas Grant on Feb. 6th, 1902, when she complained of a feeling of suffocation and inability to breathe through the nose. The right nasal passage was almost normally free, and the left one patent to an abnormal degree. There was considerable atrophy of the left inferior turbinated body, the posterior wall of the pharynx and the "arcade" of the posterior choana being visible to a considerable extent. There was a very slight tendency to alar collapse, but not sufficient to interfere with breathing. The mucous membrane was abnormally tolerant of manipulation with the probe, and in fact there was a considerable degree of anæsthesia. The exhibitor attributed the subjective obstruction to this anæsthesia. The patient did not feel the air passing through the nose, and had consequently acquired a fixed idea that it did not do so, and that she could therefore only breathe through the mouth. Dr. Grant said that this was the mechanism of many cases of subjective nasal obstruction.

Dr. SCANES SPICER was of opinion that there was marked insufficiency of passages in this case, due to stunted evolution of the nostrils, and there was collapse on inspiration. He thought the insufficiency would be overcome by dilation, wearing rubber tubes, and re-establishment of normal action of nasal inspiratory muscles. When this was done he believed, from his experience of similar cases, that the patient's sense of stuffiness would disappear.

Dr. DUNDAS GRANT said the patient was a very highly neurotic subject, and there was some, though not very great, tendency to collapse of the alæ. The left nostril, in his opinion, was at all events abnormally patent, and there was ample room for breathing purposes if only she were conscious that the air could go through.

Considerable anæsthesia of the nasal mucous membrane was present on both sides, and he believed this was a large factor in many of these cases.

A Specially Constructed Glass Tube for the Inhalation of Medicinal Powders into the Larynx.

Shown by Dr. Dundas Grant. A glass tube of about 6 inches in length is bent at one end into a crook of about ½ inch, while 2½ inches of the other extremity are bent downwards at an obtuse angle. The short crook, lying downwards, is pushed by the patient to the back wall of the pharynx, and the opposite extremity is allowed to dip into a small quantity of light powder in a watch-glass or plate; the patient then closes his lips and draws in his breath rapidly through the tube so as to inspire some of the powder. This, following the inspiratory blast, finds its way, according to the inventor of the method, into the larynx. It is a method of great simplicity, and has the advantage that it can be carried out by the patient himself under the direction of his medical adviser. Its inventor, Dr. S. Leduc, of Nantes,* strongly recommends the use with it of the powder known as di-iodoform, and he deprecates the employment of crystallines such as those of ordinary crystallised iodoform. Dr. Dundas Grant had used with it orthoform and resorcin, and had seen by the laryngoscope the powder adhering to the interior of the larynx. It had given great relief to several patients with laryngeal phthisis to whom he had given it.

Mr. A. J. Hutchison said that these tubes were not new, for he had known of them for four years. They were brought out first on the Continent, either in France or Germany. To the small extent he had employed them he had found them very useful.

Wooden Probes and Cotton Carriers.

Shown by Dr. StClair Thomson on January 10th, 1902. Dr. Thomson had met with these wooden probes in a throat clinic in

* See 'La Gazette médicale de Nantes,' 16 novembre 1901.

Germany last summer. There was nothing particularly novel in them beyond the fact that they were remarkably cheap and reliable. They were cheap because they were originally manufactured wholesale for use in the making of sausages, and were known as "Wurststäbchen," and were carefully sterilised under Government control. They could be cut in suitable lengths, and were useful as probes for applying caustics, as cotton carriers, and for other purposes. When cotton-wool pledgets had to be left in the nose, it was much easier for the patient to remove them if the cotton were first wound round a wooden probe which was then cut off flush with the orifice of the nostril. These wooden probes were kept in stock by Messrs. Mayer and Meltzer, and by Mr. Rogers, of Oxford Street.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-SECOND ORDINARY MEETING, *March 7th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.), JAMES DONELAN, M.B., } Secretaries.

Present—34 members.

The minutes of the preceding meeting were read and confirmed.

The following cases, specimens, and instruments were shown:

CASE OF COMPLETE RECURRENT LARYNGEAL PARALYSIS IN A MALE ÆT. 24 WHICH HAD REAPPEARED AFTER A PERIOD OF RECOVERY.

Shown by Dr. FITZGERALD POWELL. This patient was first seen on December 30th, 1901, complaining that he had lost his voice quite suddenly on *December 28th*. He could give no explanation as to the cause, unless it were strain from singing.

He further stated that in *February or March of* 1901 he had lost his voice quite suddenly in the same way. At this time he was not feeling very well, and three or four days after the voice

became affected he had a severe cold, with rise of temperature, which was considered by his doctor to be due to influenza.

On this occasion he was under treatment by Dr. Bronner, of Bradford, and after three months his voice returned completely, and had kept quite strong until December 28th last, when he again lost it.

There was no history or evidence of syphilis, and nothing abnormal could be found in the chest. He complained of periodic headache and attacks of supra-orbital neuralgia. He had a spur on the right side of the septum nasi and a polypus causing nasal obstruction.

The most careful examination and investigation of his case failed to give the slightest explanation of the cause of what was found in the larynx, viz. *complete paralysis of his left vocal cord*, which hung in the cadaveric position, the inner edge of the cord being curved with the concavity towards the median line.

So far as could be observed there was an entire absence of the usual causes which produce this paralysis.

As regards treatment, the spur on the septum had been removed and the polypus snared, and he was placed on iodide of potassium up to twenty grains three times a day, and strychnine had been administered.

On February 19th the paralysis was still complete, but on March 5th there was some movement in the cord, and the patient stated that on February 22nd his voice had suddenly improved and was now much better, though still hoarse and weak.

The same treatment is being continued.

Sir FELIX SEMON suggested that the most likely explanation of the occurrence of the paralysis in such a case was peripheral neuritis. The history in this case of influenza would be quite sufficient to account for the occurrence of the first paralytic attack. The nerve being afterwards left in a weakened state, recurrence of the paralysis on slight provocation was no unlikely sequel; some extra vocal effort on the part of a patient or a cold would be sufficient to produce such a recurrence. It was now becoming a general opinion that peripheral neuritis was a rather frequent cause of laryngeal paralysis. He had lately read a very interesting monograph by Cahn, of Strassburg, endeavouring to establish that the most frequent cause of laryngeal paralyses in tabes was peripheral neuritis. At any rate, it was a subject well worth any one's while to follow up.

Dr. FITZGERALD POWELL thanked Sir Felix Semon for his remarks

on the causation of the alternating condition of this case, but he would like to hear from him what was the cause of the peripheral neuritis. Did he look on influenza as the cause, although there was no *definite* history of the patient having had it previous to the first attack, and he certainly had not had it on the last occasion of the paralysis?

Sir FELIX SEMON said, in reply to Dr. Powell's question, he regarded the toxin of influenza as the cause of the peripheral neuritis.

CASE OF HÆMATOMA OF THE VOCAL CORD IN A FEMALE ÆT. 29.

Shown by Dr. FITZGERALD POWELL. The patient was first seen on March 4th, complaining of hoarseness and loss of voice, which came on suddenly in February of this year. On examination of the larynx the left vocal cord was seen to move very sluggishly on phonation, and an extravasation of blood was seen in its whole length, forming what he might describe as a "hæmatoma of the cord." The nose, pharynx, and larynx were the seat of chronic inflammation. The patient had lost her voice three years ago, but it returned after six months' treatment.

Dr. F. DE HAVILLAND HALL asked if the attack of hæmorrhage coincided with the menstrual period, or whether there was any catamenial disturbance, because most of these cases occurred in women, and either coincided with or preceded the catamenia, or else some menstrual disturbance.

Dr. DUNDAS GRANT said it would probably be within the memory of some of the original members of the Society that he had showed a case identical with Dr. Powell's case at one of the earliest meetings, in which the hæmatoma recurred on several occasions. To the best of his recollection it was associated with menstruation, but he had not had an opportunity of looking up the notes, and would not therefore speak with certainty on this point. The case was reported in the 'Proceedings' of the Society.* Ultimately a small angeioma near the junction of the anterior and middle third developed on the upper surface of the left vocal cord. The patient had gone to South Africa, and he did not know what had happened since.

Dr. J. DONELAN thought the case was the result of influenza, from which the patient was still suffering; she had the characteristic eye. He had had two cases under his care—both the patients were men—in whom the hæmatoma had followed influenza and severe coughing. Some of the subglottic veins were enlarged, and from these tracheal hæmorrhage had also taken place.

* See vol. i, p. 2.

Dr. FitzGerald Powell regretted to say that though he had promised to inquire with regard to the menstrual periods he had forgotten to do so, but he would ask the patient the next time he saw her. So far as influenza was concerned, he supposed the last speaker hardly wished to infer that influenza was the cause of the extravasation of blood otherwise than by causing trauma from coughing.

A Modification of Mackenzie's Laryngeal Forceps for Removal of Growths in the Anterior Commissure and Drills for draining Maxillary Antrum through Tooth Socket.

Shown by Dr. FitzGerald Powell. The forceps were simply Mackenzie's laryngeal forceps with the cutting ends turned forwards. He found that they were useful in removing growths from the anterior commissure, and he thought others might find them useful in cases where there was a difficulty in removing these growths with the straight forceps. At the same time he did not claim any "proprietary rights" in the instrument, which was Mackenzie's with the slight alteration mentioned. The chief point of interest in the drills was their size, the largest being the size of a No. 14 silver catheter; these drills, he thought, provided a means of curing the great majority of cases of empyema of the antrum. They made a large opening through the tooth socket, after extraction of the first molar or second bicuspid, through which a tube could be introduced, and through which the antrum could be freely curetted and washed out. He thought there were only a few cases in which what is known as the radical operation was required.

The President thought that unless more than one tooth was extracted the drill and tube were rather large to get in without damaging the teeth at the sides of the socket.

Dr. StClair Thomson presumed that the exhibitor, in claiming that the majority of cases of empyema of the antrum might be radically cured by drainage through the tooth socket, included only those cases in which none of the other cavities were affected. At one time he himself was inclined to enlarge the alveolar opening, but he came to the conclusion that it was not the size of the opening that was of importance in effecting a cure, because when one had had considerable experience in opening antra, one found that there were many cases in which a large drainage through the alveolar border would

never overcome the difficulties. He referred to those cases with dissepiments from the floor, or with the mucous membrane in so altered a condition that suppuration was liable to be started again by the first fresh infection. Perhaps Dr. Powell did not mean that the cases were *permanently* cured.

Dr. DUNDAS GRANT, in referring to the alveolar perforation, said he generally made use of a hollow trephine, the advantage of which was that it cut out the piece of bone which one removed instead of sending it or the bone-dust into the antrum. On one occasion, however, when he fancied he must have used almost excessive speed with it, there was actually a sequestrum of a little piece of bone around the trephining hole. Others had observed this fault as well, but he did not know the cause of its appearance. He thought it might be due to the intense heat generated; he did not use an electric motor, but a foot-drill.

With regard to the forceps, he thought the variation a most excellent one. If criticism *a priori* were permissible, he would say that the vertical shanks were rather too long; the upper angle would impinge upon the hard palate in a good many cases. Otherwise the instrument was an admirable one.

Dr. HERBERT TILLEY said that an almost precisely similar forceps had been in use for the last two years at the Throat Hospital, Golden Square, and was introduced there by Dr. Lack.

Dr. LAMBERT LACK said the forceps very greatly resembled some he had had made, and which had been in use at the Throat Hospital for over three years. In addition to the curve at the tip his forceps had an obtuse angle, which he thought a great additional advantage, as it held the epiglottis out of the way.

Dr. FITZGERALD POWELL, in reply to the President's remarks on the drill, said that it would be clearly seen in the example which he showed them, where the hole was made by the largest instrument, which was bigger than that of a No. 14 silver catheter, that the teeth were not impinged upon in any way. Cases were occasionally met with in which the teeth were so close together that there was some difficulty in this respect, but in the vast majority of cases one obtained a good large opening in the way he advocated, through which drainage could be thoroughly effected, and *through which the antrum could be curetted.*

In reply to Dr. StClair Thomson, he said that if the ethmoidal sinuses were affected, it would be necessary to curette the sinuses at the same time that the antrum was being opened. One came across cases occasionally in which it was necessary to open the anterior wall and curette the sinuses very freely, but in all ordinary cases—which constituted the great majority—the measures he recommended were sufficient to effect a cure. With regard to Dr. Tilley, he only wished to emphasise that the forceps he showed were Mackenzie's laryngeal forceps, modified by having the cutting point turned forward, and they were absolutely and totally different from Dr. Lack's forceps, which were short and very light, with an obtuse angle instead of the right angle of Mackenzie's, and were practically only suitable for children.

In using Mackenzie's forceps he had found some difficulty in re-

moving growths in the anterior commissure, and it occurred to him if the points could be turned forwards the growths could be more easily reached. Hence the forceps he now showed.

Case of Paralysis of the Left Vocal Cord.

Shown by Dr. Willcocks. The patient, a postman æt. 45, had complained of cough and huskiness of the voice since last Christmas. On examination the left vocal cord was found to be completely paralysed, both cords were white, and there was no local swelling in the larynx. There was no history of syphilis, and no signs of any source of intra-thoracic pressure, such as aneurysm or tumour.

Dr. de Havilland Hall said that though they must remember the possibility of peripheral neuritis in this case, yet there was less evidence of it than there had been in the case of Dr. Powell's patient. At the age of forty paralysis of the left vocal cord indicated very possibly the existence of an aneurysm. He called to mind a case of Dr. Fincham's at the Westminster Hospital, where the only sign of an aneurysm for many months—in fact, nearly a year—was the cadaveric position of the cord. Eventually the patient developed well-marked physical signs of aneurysm, from which he died. In this case there might be no physical signs of aneurysm for many months to come, but they must still bear in mind the possibility of its being aneurysmal.

Mr. P. de Santi had shown a similar case to the Society only two meetings ago, in which, if he remembered correctly, Sir Felix Semon had considered there was an aneurysm in spite of the absence of the physical signs. The patient, a woman, was skiagraphed, and a well-marked dilatation of the arch of the aorta was easily made out; since then he believed the patient had been under the care of Dr. de Havilland Hall.

Sir Felix Semon had seen comparatively often the production of laryngeal paralysis in cases in which the aneurysm was so small that there were practically no physical signs to be obtained. The absence of physical signs of aneurysm in the chest was certainly no proof of its non-existence. He recollected a case which would serve as a very apt illustration. Many years ago the head-master at one of the big public schools consulted him on account of frequent fatigue of the voice. On examination of the throat he found paralysis of the left abductor. He then examined the chest, and thought there was possibly a very little dulness over the lower part of the sternum. Barring this dulness, there were no physical signs whatever; still, he suspected the presence of aneurysm. The patient was induced to see Dr. Ord, of St. Thomas's Hospital, who found the same condition and

agreed entirely with the speaker as to the probable existence of aneurysm. The patient was at the time just about to start for a tour in Switzerland, where he intended spending the holidays. Both Dr. Ord and he advised him to go home and rest, and undergo a course of Tufnell's treatment. Dr. Ord knew the family medical attendant, and wrote to him expressing their joint opinion as to the case, in reply to which he received a letter saying that the writer wished devoutly there were no consultants in London, for they only needlessly frightened patients, and that he had strongly advised the patient to proceed with his arranged plans and go to Switzerland. This was done, and the patient died four weeks afterwards from hæmorrhage, caused by the bursting of a small aneurysm, which had, indeed, been present. The moral was obvious.

Dr. DONELAN said, in reference to the remarks just made by Sir Felix Semon, he had shown to the Society in June, 1901, a sketch of an aneurysm of the aorta in which paralysis of the left vocal cord was the only physical sign during life. The patient was an Italian man æt. 39, whom he had been asked to examine. He considered that the paralysis was probably due to an aneurysm. On the morning of the day following this examination the patient was suddenly seized with what seemed to be angina pectoris, became rapidly collapsed, and died within two hours of the seizure. The *post-mortem* showed a small oval aneurysm on the postero-superior aspect of the aorta, immediately outside the origin of the left subclavian, compressing the recurrent nerve.

Dr. WILLCOCKS had no further remarks to add, except that he was glad of the hint given by Mr. de Santi with regard to the X-ray examination. He had not taken a skiagram yet, but would do so. He thought Dr. Hall was most likely correct in referring to the case as of aneurysmal origin. He saw the case for the first time a month ago, when he had examined the man very carefully with that view in mind, but he had been totally unable to satisfy himself as to the existence of an aneurysm; he had shown the case to some of his colleagues at Charing Cross, and they were all of opinion that at present there was no obvious sign of aortic dilatation.

CASE OF LARYNGEAL STENOSIS DUE TO CICATRICIAL CONTRACTION IN INTERARYTÆNOID REGION.

Shown by Mr. H. BETHAM ROBINSON. The patient, a young man æt. 20, was brought to him on account of the difficulty in breathing on exertion.

According to the history he had had a severe attack of what was stated to be diphtheria some years ago; after it he had had no voice, but this had come back very slowly. Eight months

ago the voice was only a squeak, but recently there had been great improvement, so that now there was only huskiness.

Examination showed a very large perforation of the nasal septum, involving both bone and cartilage, and loss of the uvula. In the larynx there was slight catarrhal reddening of the vocal cords, but the marked feature was the loss of abduction of the cords on deep inspiration with some stridor. On phonation the cords came together to the mid-line, except between the arytænoids. This laryngeal condition was due to a cicatricial web passing between the arytænoids, evidently the result of previous inflammation. Although no history could be obtained, syphilis explained the three lesions mentioned.

The PRESIDENT said the question was whether the cause of the condition was syphilis or diphtheria; the nasal trouble might, he thought, be caused by the latter, and possibly the laryngeal trouble also. He suggested that the man ought to have tracheotomy performed as soon as possible.

Sir FELIX SEMON drew attention to the adhesion between the posterior ends of the vocal cords in the very small part just visible above the interarytænoid fold. Supposing the cicatrix had been a little bit lower, everybody would have looked on it as a case of bilateral paralysis of the glottis openers. This case reminded him of the well-known case of Sidlo's, of Vienna, in which a similar diagnosis was made, and after death a cicatrix was found on the posterior wall of the larynx. The case to which he referred was extremely interesting as showing how careful one had to be, if the cords were lying close together, not to rush to the conclusion that the condition must needs be of nerve origin, and to remember the possibility of a mechanical origin. As to the particular case under discussion, he thought the perforation in the nasal septum and the absence of the uvula would make him very sceptical in regard to the diphtheritic origin of the case; there was, on the contrary, strong evidence in favour of syphilitic mischief.

Dr. DUNDAS GRANT thought it was very likely a case of perichondritis, such as occurred in typhoid fever; there was decubital ulceration from the pressure of the cartilages against each other. If the man were left *in statu quo* he was in considerable danger, but he did not consider that the operation for the relief of these cases was very satisfactory.

Dr. STCLAIR THOMSON said that in the absence of reliable history the evidence in favour of syphilis was not more than a suspicion. If the perforation in the nose occurred when the man was not having any treatment, it was very usual to find retraction afterwards causing some falling in of the nose, and even retraction round about the perforation, just in the same way as was found with the soft palate and uvula in inherited syphilis. It might be a coincidence that the

syphilitic process in the larynx took place exactly in the middle line, but he thought it more likely to be of diphtheritic origin. He agreed with the President in thinking that tracheotomy was urgently called for.

Mr. Robinson, in reply, thought all the lesions were due to syphilis, and could not agree with the diphtheria explanation put forward. Of course, if they wanted to explain the condition by two causes, diphtheria and syphilis would do, but such was unnecessary when one common cause was sufficient. With regard to the question of operation, the lad was a pupil-teacher, and the whole matter had been put clearly before him and his parents, explaining the risks he ran. They were, however, unwilling, bearing in mind that he was dependent on his voice for his living, to have anything whatever done, and there the case must rest.

Sections of Tuberculous Growth of Mucous Membrane of Right Middle Turbinal in a Man æt. 50.

Shown by Dr. Adolph Bronner. The patient from whom this growth was removed was first seen on June 20th, 1901. He had had nasal obstruction off and on for some years, with discharge into throat; he could never smell well, but taste was fairly good. He gave a history of an ulcerated throat one year previously. The nose had been worse for some weeks, with pain over the bridge. He had noticed a rather offensive smell from the right nostril for two or three weeks.

The apex of one lung was affected. Both nostrils were blocked by swollen mucous membrane of lower turbinals. This was removed by a snare and galvano-cautery.

On July 25th the right middle turbinal was much enlarged, and on it a large patch of ulcerated mucous membrane. A piece was removed by snare for examination. Trichloracetic acid was applied, and aristol insufflations were ordered.

On September 24th there had been very little discharge or bad smell or pain for three to four weeks, and the nares were patent. The right middle turbinal was still enlarged, but the ulceration had healed.

The Clinical Research Association reported: "This growth consists of tuberculous granulation tissue in which are many miliary tubercles with large giant-cell systems."

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Dr. StClair Thomson suggested that Dr. Bronner be invited to give a specimen to the museum, because, as far as his recollection went, it was extremely rare to see a specimen of tuberculosis of the middle turbinal. The best article he knew on primary tubercle in the nose was that written by Mr. Steward in the 'Guy's Hospital Reports,' vol. liv, where it was pointed out that primary tubercle in the nose generally attacked the septum, and that next in frequency came the inferior turbinal, but that the middle turbinal was very rarely subject to tuberculosis.

Case of Tertiary Intra-nasal Syphilis in which the Right Frontal Sinus had been opened twice with Negative Results, in a Married Woman æt. 48.

Shown by Mr. P. de Santi. The patient was first seen five weeks ago, complaining of great pain at the back of the nose and head, also of a foul discharge from the nostrils and occasional discharge of pieces of bone.

She had been married seventeen years, and had had three miscarriages and one seven months child born dead.

Nine years ago she first noticed a discharge of small hard lumps of a greenish colour from the left nostril, also occasional swelling at the root of the nose; soon afterwards a similar discharge occurred from the right nostril, and the discharge, which had included frequently pieces of bone, had continued ever since, and had got worse and worse. Three and a half years ago she had had paralysis of left facial nerve, which came on suddenly, and cleared up entirely after about eighteen months' time.

In 1901 the patient was an in-patient at University College under Mr. R. Johnson for nasal discharge and headache. There was pain over bridge of nose and right frontal sinus, slight diminution to tactile sensation over left side of body, and slight apparent weakness of facial muscles on the left side. The right frontal sinus and maxillary antrum were explored, and found to be healthy.

The patient left the hospital unrelieved, and on September 25th, 1901, was admitted into Charing Cross Hospital, under Mr. Waterhouse, and the right frontal sinus was opened, a little purulent material exuding; the mucous membrane was

in a thickened and catarrhal condition. An attempt to pass a small rubber tube down the infundibulum was unsuccessful, and a strip of gauze was substituted. The frontal sinus was packed with iodoform gauze, and the usual dressing applied. After the third day a No. 2 catheter was passed down infundibulum, and this was done daily, the parts being washed out with boracic solution. The fœtor became less, and after a few days' treatment the patient passed a large mass of necrosed bone, which consisted of a part of the lateral mass and ethmoidal cells. The frontal wound was gradually allowed to heal. Patient was discharged on October 10th, 1901, unrelieved. She now complained of intense headache, loss of sleep, diarrhœa, and a half-choking sensation. The pains in the head appeared to be referred to the back of the nose and frontal regions.

Examination of the nose showed large greenish-black sloughs in the posterior region of the intra-nasal cavity; there had been extensive destruction of the bony lateral masses, but the septum was intact.

The patient's condition, in Mr. de Santi's opinion, was due to syphilis, and she had had large doses of iodide of potassium, but without benefit. Suggestions as to operative treatment were invited.

Dr. DUNDAS GRANT said the woman seemed to be in a very serious condition. He strongly suspected tertiary changes were taking place in the sphenoid, and probably there was a sequestrum at the junction of the sphenoid and the vomer; he thought Mr. de Santi might explore this region with his finger. He had had a similar case to this under treatment, which consisted in taking the patient into hospital and giving her the good feeding up which her circumstances at home rendered impossible. He was giving her inunctions of mercury with iodide of potassium and opium internally. He recommended the same treatment to Mr. de Santi's patient.

Dr. HERBERT TILLEY agreed with Dr. Grant as to the possibility of deep-seated bone mischief in the sphenoidal region, and cited a similar case which died of basal meningitis after temporary improvement by mercurial inunctions and constant nasal douches. The pus between the middle turbinal and the septum, the pain on the top and at the back of the head, together with deep-seated pain in the right eye and frequent disturbances of vision, were all symptoms very suggestive of suppuration in the sphenoidal sinus.

Dr. VINRACE said he thought that before any further operation was proposed in this case, it might be desirable to review very briefly what had been done. He had, on a previous occasion, asked what were the

indications for opening the frontal sinus, and what were the benefits claimed for it; and the answer he received was that the operation was performed in accordance with the best canons of rhinological surgery, and that the patient was very much better for it. This answer only left him to speculate in what details the benefits accrued. In this particular case he would like to know why it was that the frontal sinus was opened. It was opened for the first time about two years ago, but nothing of a morbid character was found. Twelve months afterwards it was opened for the second time, and he believed it was stated that a *little* pus was found in it. Now what he wished to know was exactly what benefit had followed the surgical measures adopted in these two operations. As far as he could gather from the patient, she had been in trouble for nine years, but never in serious trouble till the operations were performed. To use her own words, she had a "dirty nose" for several years. After the first operation was performed, as he gathered from her, she was worse in health and new symptoms arose; even after the second operation, the patient admitted that her symptoms were very much aggravated. Having regard to these reports from the patient, he thought very great care should be exercised before any further operation was done. Assuming that when the first operation was done the patient was suffering from active syphilis, one of the last things that it would have occurred to him to do would have been to operate on the nose in the extravagant way in which it had been done in this case. He did not wish to put any member in the position of an oracle pronouncing judgment upon this question, least of all the exhibitor, since the surgical interference referred to had been carried out before the patient came under his care, but if any member could enlighten him upon the points he had raised he would indeed be grateful.

Mr. DE SANTI, in reply, said the first point to be mentioned was in regard to the diagnosis which was raised by Dr. Grant. There could be no doubt that the woman was suffering from tertiary syphilis of the nose, and that the disease had penetrated as far back as the region of the sphenoid bone. Nor was there any doubt that her condition was a somewhat serious one, and that she must undergo some further operation. She should, he thought, be examined thoroughly under an anæsthetic, and the posterior nares be carefully explored with the finger, and, of course, what might be done afterwards depended on what might be found. If the sphenoid bone were necrosed and firmly fixed, it would not be safe or wise to try and get the necrosed bone away, unless it would come away with the exercise of very little force. If a sequestrum had formed, as he feared, its removal might be quite easy, or, on the other hand, difficult and dangerous.

With regard to Dr. Vinrace's remarks, he had to say that when the patient first went to University College Hospital, and was under the care of Mr. Johnson, she had very intense headache, and there was considerable pain over the bridge of the nose and the right frontal sinus. The patient localised most of the pain in the head on the right side of the frontal bone, and the area of tenderness to pressure was over the right frontal sinus, and he supposed these were the reasons why the right frontal sinus was opened. Moreover there was a nasal

discharge consisting of thick greenish pus, and this was seen mostly in the middle meatus. He could not go further than that as to the reasons which probably prompted Mr. Johnson to operate on the right frontal sinus. Later the patient was at Charing Cross Hospital, complaining of similar symptoms, only they were aggravated. It was only fair to Mr. Waterhouse to say with regard to the second operation on the frontal sinus, that although the woman now denied it, it was against his advice that the operation was undertaken. The patient insisted on Mr. Waterhouse doing it, and it was done under protest. One of his colleagues at Charing Cross, Mr. Bloxam, felt certain there was nothing the matter with the right frontal sinus before it was operated on again by Mr. Waterhouse, but was of opinion that there was a mass of dead bone at the back of the nose.

He could not go further into the subject of the indications for and advantages of the frontal sinus operation, but as regards this particular case, the reason for operation was the pain referred to the right frontal sinus, which was constant and excessive before the sinus was opened.

A Case of Angioneurotic Œdema of Right Hand with recently developed Attacks of Difficulty in Breathing.

Shown by Mr. P. de Santi. The patient, a married woman æt. 26, was in the London Hospital four years ago with swelling of the right hand and forearm, and angioneurotic œdema was diagnosed. The treatment consisted in elevation of the limb.

Since then she had had several further attacks, always of the right hand. The attacks began with a feeling of tightness in the hand, rapidly followed by great swelling of the fingers, hand, and forearm, the fingers becoming almost black in colour, and the rest of the affected parts bluish red. The attacks lasted a variable time, and then the parts returned to the normal. There was no particular periodicity in the attacks, and no family history of similar conditions. About six weeks ago the right side of the face became swollen, and for three weeks the patient was unable to open the mouth properly, having to live on slops. Then followed suffocative feelings in the throat, which occurred both by day and night, the patient feeling as if the throat were being tightly gripped. The attacks were slightly relieved by adopting the sitting posture. The hand had not been affected for four months.

Examination of the larynx revealed no œdema or abnormal condition. The case was brought forward as, in these cases of angioneurotic œdema, of which Mr. de Santi had seen two, sudden œdema of the larynx proving fatal might occur.

Osler had knowledge of one family extending to five generations in which twenty-two various members had been attacked by angioneurotic œdema, and in which two had died of œdema of the larynx. This disease was characterised by the sudden onset of local œdematous swellings, more or less limited in extent and of transient duration. The parts attacked were usually the face, back of the hands, the buccal or pharyngeal mucous membrane, or the larynx. Mr. de Santi would be glad if any members could inform him if they had had any experience of throat trouble in these cases of angioneurotic œdema—otherwise called Quincke's disease.

Dr. DE HAVILLAND HALL thought this an extremely interesting case. He had a case under his care which he saw from time to time, the patient being a lady of forty-four or forty-five years of age, who was subject to attacks of angioneurotic œdema of the neck and buccal mucous membrane, and as she had had on one or two occasions great difficulty in breathing he inferred that the symptoms extended to the larynx. Unfortunately he had never been able to see the larynx affected; but usually he saw the buccal mucous membrane in an œdematous condition. This patient was undoubtedly a gouty subject, and she had derived most benefit from a course of treatment directed to the gout, and from alkalies. She was formerly a patient of his late colleague, Mr. Bond, who had been treating her with bicarbonate of potash and bark with considerable benefit, and occasionally doses of blue pill. He had not seen the patient now for three or four months, but he had heard that the attacks were getting less frequent. He sent her to Llandrindod Wells for a course of treatment, and she had come back very much better. He had seen another case in a boy who had no throat complication, but who was subject to attacks of angioneurotic œdema, which were located in the back of the left hand and wrist. It was an interesting case, as the patient had developed cyclic albuminuria. When in the recumbent position there was no albumen in the urine, but on getting up and about a trace was found. He thought this combination of the two conditions—angioneurotic œdema and cyclic albuminuria—in the same patient a matter of some interest.

Dr. EDWARD LAW thought that some of the members might remember that five or six or seven years ago he had brought before the Society a case of well-marked Quincke's disease.

Mr. DE SANTI, in reply, said he should be pleased to adopt the treatment mentioned by Dr. Hall.

Case of rapidly recurring Papilloma of the Larynx.

Shown by Dr. Lambert Lack. The patient, a Swiss waiter æt. 21, had suffered from hoarseness for four months. When first seen six weeks ago there was what appeared to be an ordinary fairly large papilloma on the anterior part of the right vocal cord.

This was at once removed under cocaine. Subsequently there was considerable congestion of the vocal cords, which increased during the following three weeks until both cords appeared red, thickened, and irregular, resembling the "fleshy granulating" cords often seen in tubercular disease. The patient was "run down," and had considerable cough and expectoration. He was now much better, and the local condition had cleared up, but on examining the larynx it would be seen that the growth had recurred, and there were at least two distinct fresh growths on the other cord.

Mr. Lake said he could not help thinking that in this case if Dr. Lack removed the growth, the careful bacteriological examination of a portion of such a rapidly growing papilloma might throw some light on its causation; micro-organisms that were found might serve as an important aid.

The President, from a cursory examination, thought the case was suitable for the application of the galvano-cautery.

Case of Traumatic Tracheal Obstruction.

Shown by Dr. Dundas Grant. Edith C—, æt. 22, was first seen on February 13th, 1902, complaining of difficulty and loudness in breathing, especially when hurrying. These symptoms had existed since an accident at three years of age, when she fell on the blade of a knife and punctured her windpipe. She had no difficulty in breathing at night, but the dyspnœa had been getting worse during the last six months. It was worse after food. There was no indistinctness in her speech, but a slight apparent effort. The left vocal cord was completely fixed, and without doubt the left recurrent laryngeal nerve must have

been injured. The extremely late period at which the narrowing had more strongly asserted itself was difficult to explain; it was hardly likely that there was anything in the way of a polypoid granulation, but more probably cicatricial contraction. Dr. Grant had advised that she should come into the hospital for a more thorough examination, and if possible for the introduction of a tube into the trachea for direct inspection.

Case of Rhinorrhœa in a Girl æt. 9.

Shown by Dr. Cathcart. Since the patient was two years old she had had a thin watery discharge from both nostrils, which caused excoriation of the upper lip. During the last six years she had twice been operated on for adenoid growths, and on four other occasions the nose had been examined under an anæsthetic and either curetted or cauterised with nitrate of silver or the electro-cautery.

Everything in the way of drugs had been tried, both internally and locally, but the discharge still continued.

The President said information was desired as to the treatment to be pursued.

Dr. de Havilland Hall had had a case at Westminster Hospital, and on measuring the fluid he found it amounted in the twenty-four hours to nearly a pint. The fluid was clear and limpid, and came undoubtedly from both nostrils, and not from any other part. At that time he had thought the case due to a vaso-motor condition. His patient had derived most benefit from mustard foot-baths with morphia and atropine. He had originally been under his care sixteen or seventeen years ago, and he had seen him quite recently—during last week,—and he had now nasal polypi. When he felt the attacks coming on he put his feet into the mustard foot-bath and took a dose of 1 minim atropine and 5 of solution of hydrochloride of morphia. In Dr. Cathcart's case he would feel inclined to try a weak spray of adrenalin solution.

Dr. StClair Thomson said it was very rare to find this condition of uncomplicated nasal hydrorrhœa in a patient so young as nine years. The cases which had come under his observation had been much older. As to their treatment, speaking from personal experience, he thought it extremely unsatisfactory. By giving placebo treatment many cases would undergo a temporary spontaneous cure, but the symptoms were quite likely to come on again at any time. Yet a certain number of cases seemed to be relieved by the use of

atropine, particularly if it was combined with Liq. Strychniæ, as suggested by Lermoyez, whose contention was that the atropine checked the glandular secretion, and that the strychnine was beneficial to the vaso-motor paresis. He had given a pill containing extract of belladonna, quinine, and extract of nux vomica. The results were uncertain from the use of adrenalin, for cases were published in which the adrenalin, instead of being beneficial, made the patients very much worse. He had heard of a city man who particularly wanted to attend a public meeting, and had adrenalin administered to him in order to tide him over the meeting, with the result that he was so much worse that he was unable to go at all, whereas without the adrenalin he could have got through with two or three handkerchiefs. He would like to hear from other members what results, even if negative, had followed the use of adrenalin in their hands. In more than one case in which he had explained the condition of affairs, and refrained from local treatment, the patients had gone elsewhere, and had a great deal of the galvano-cautery, but with what results he did not know. General treatment and that of hydrotherapy at different health resorts had at the least an elevating effect.

The PRESIDENT said he could only suggest the same treatment he had recommended for Mr. Lawrence's patient at the last meeting—the application of the continuous current externally to the nose. He wished to add that adrenalin required to be used carefully; if it was applied too strong it might produce prolonged sneezing. He employed a solution of 1 in 10,000 of adrenalin chloride to contract the nasal mucous membrane.

Sir FELIX SEMON said he had lately frequently used adrenalin in view of the many recommendations bestowed upon that remedy, and he found that for about an hour or two after its administration it produced a stoppage of secretion and feeling of absolute dryness in the nose, followed by infinitely greater discharge than previous to its use.

Mr. WAGGETT considered that it was worth while to make trial of the treatment of Lermoyez in its entirety, for he had had three or four lady patients under his care who had taken the trouble to pursue the treatment regularly, and had obtained complete relief of hydrorrhœa. Whether or no this was to be permanent he was unable to say. The syrup used contained strychnine and atropine (*vide* 'Journal of Laryngology,' vol. xv, p. 442).

Dr. LAW, replying for Dr. Cathcart, said that adrenalin had been tried, but without success, also many other remedies.

Dr. BRONNER asked if any member had tried the desiccated suprarenal extract, which was in the form of a powder, and was used as a snuff. He thought it acted better than the solution of adrenalin. It was used 1 in 10 with boric acid and a little menthol.

CASE OF ATROPHIC RHINITIS IN WHICH MELTED PARAFFIN HAD BEEN INJECTED INTO THE INFERIOR TURBINATE BODIES WITH GOOD RESULTS.

Shown by Mr. G. LAKE. The patient, a woman æt. 25, had been afflicted with fœtid atrophic rhinitis for many years. Crust formation had been got under by the usual treatment, but the patient was dissatisfied, as she felt no air passing down the nose. This suggested to him the idea of contracting the passages by making an artificial inferior turbinate by means of submucous injections of paraffin.

The injections were made under the posterior surface of the remnant of the inferior turbinate, about ♏ v each time with intervals of one week. The total increase of length obtained was not great, but the relief was most satisfactory to the patient.

The needle required was one of fair calibre, three inches in length, and attached to the syringe by means of a screw. The syringe employed was one with metal bands connecting the metal ends and worked with a screw piston to overcome the friction caused by the long needle.

The PRESIDENT asked Mr. Lake if the patient had benefited as far as the symptoms were concerned.

Dr. DUNDAS GRANT said that the turbinated bodies looked an excellent size at present. He asked whether a local anæsthetic was required, and whether cocaine was contra-indicated, owing to the fact that the contraction it would produce would militate against the successful injections.

Mr. WAGGETT thought the most remarkable point about the case was the colour of the inferior turbinals, which was now practically of a normal tint. He had closely questioned the patient, and from her replies he had gathered she must have enormously improved. He heartily congratulated Mr. Lake on his very ingenious new method of treatment.

Dr. LAMBERT LACK said that although the patient herself was positive that she had derived great benefit, the treatment seemed to him utterly irrational and against the modern ideas of the pathology of the disease. He thought much more evidence was required before this treatment could be accepted.

Mr. LAKE, in reply, said he had used cocaine, and that it answered very well. With regard to the symptoms, the girl bothered him after the crust formation ceased because she could not blow her nose; she had plenty of room, but she could not feel air pass down the nose.

He was pleased to hear Dr. Lack's strictures, because it was a question of some considerable interest as to what was the pathology of the disease. People talked of the destruction of the turbinals as if this were part of the disease, but why did they disappear?

In the present case the patient expressed herself as more comfortable with the substituted inferior turbinals, which merely relieved the symptoms. He did not feel so confident in the present pathology of atrophic rhinitis as described in the text-books to quite accept the explanations given by them as correct.

Papillomatous Growth on the Posterior Edge of the Vomer.

Shown by Dr. Herbert Tilley. The patient, an adult male, had been under treatment for almost complete nasal obstruction in the left nostril. In the course of examination a small whitish growth the size of a yellow pea was seen by posterior rhinoscopy situated on the posterior edge of the vomer about the middle of its length. The growth was dead white in colour, contrasting very markedly with the normal redness of surrounding structures.

The growth had not been touched by finger or instrument, and hence the exhibitor could say nothing of its feel or consistence. He had once seen a definite papilloma growing from that spindle-shaped mass of mucous membrane so often seen on the posterior edge of the vomer, but had never met with a condition similar to that in the case exhibited. He regarded it as a harmless curiosity.

The President said in regard to this case of growth on the edge of the vomer, he would not like to say without feeling it with his finger whether it was papillomatous or cartilaginous in character. He thought the growth different from the ordinary swellings seen near the posterior margin of the vomer.

Sir Felix Semon said that in that part of the vomer one often saw little symmetrical thickenings. This growth might simply represent an excess of the ordinary thickening.

Case of Syphilitic (?) Disease of Larynx simulating Malignant Disease.

Shown by Dr. Herbert Tilley. The patient was a well-proportioned man æt. 28. For six weeks he had complained of "hoarseness," and for the past week of pain on swallowing, which shot from the throat towards the right ear.

The irritation in the throat caused a cough, but at no time had he expectorated blood. The patient had syphilis about five years ago.

The larynx was uniformly congested, but the right vocal cord was motionless on phonation, and there was considerable, but uniform, swelling of its posterior half. Below the level of the cord for about half an inch in a vertical direction well-marked ulceration was seen; there were no prominent edges or projections from the surface of the ulcer. The right arytænoid cartilage moved on phonation. A hurried examination of the chest had been made, but so far as it went no evidences of tubercular mischief were obtained. The appearances in the larynx simulated malignant disease, but at present the patient was being treated on the hypothesis that the lesion was a syphilitic one.

Dr. FitzGerald Powell did not quite catch whether or not the chest had been examined. It seemed to him, from the appearance of the condition, it was much more likely to be tuberculosis than either syphilis or malignant disease. The larynx was pale in colour, there was present to a fairly large extent cough and expectoration, according to the man's own account. He seemed to have been having night sweats, and showed other symptoms of tubercle; under these circumstances he thought that until the sputum had been examined, and they knew the condition of the chest, it was almost impossible to come to a definite conclusion with any certainty as to the condition, but he believed it to be tubercle.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-THIRD ORDINARY MEETING, *April 11th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.), JAMES DONELAN, M.B., } Secretaries.

Present—32 members and 1 visitor.

The minutes of the preceding meeting were read and confirmed.

The following gentleman was nominated for election:

Woods, Robert Henry, 39, Merrion Square East, Dublin.

The following cases, specimens, and instruments were shown:

CASE OF LARYNGEAL GROWTH IN A MAN ÆT. 50.

Shown by Dr. WYATT WINGRAVE. The patient was a dock labourer, and when first seen, about two months ago, complained of hoarseness of twelve months' duration, with some dyspnœa on exertion for past four months. He admitted having a "chancre" twenty years ago, but without any sequelæ.

On laryngoscopic examination, two smooth opalescent swellings were seen overhanging the right half of the glottis. The cords were normal in appearance and texture. He was ordered sedative inhalations, and carefully watched. The symptoms considerably improved, but the swellings distinctly increased in size, a third one appearing just above the left capitulum.

Fourteen days ago considerable œdema of uvula and palate appeared.

The voice was at the present time very good, and there was very little dyspnœa on exertion.

He had not lost weight, and felt quite well. There were no enlarged cervical glands.

Case of Tumour of Larynx.

Shown by W. H. Kelson. The patient, a woman æt. 74, came to hospital suffering from hoarseness of nine months' duration. On examination, there was seen to be a rounded greyish coloured tumour, about the size of a marble, lying on and concealing the anterior part of the left vocal cord, and apparently originating from the left ventricle. It was firm when touched with a probe; the cords moved well, but were prevented from coming into apposition by the growth.

He thought it was probably a cystic fibroma.

Dr. Scanes Spicer thought the tumour was a cyst. It was white, and shaped like a pearl.

The President also thought of its possibly being a so-called prolapse of the ventricle, but it did not look solid enough for that.

Dr. Jobson Horne said he could not be quite sure from inspection alone whether the growth lying on the left vocal cord were solid and dependent from the roof of the ventricle, and therefore similar in its pathology to one he had described (*vide* 'Proceedings,' vol. v, p. 98), or whether it were of a cystic nature, and formed by the prolapsed lining of the ventricle. Its appearance, he thought, was suggestive of the latter.

Dr. StClair Thomson had seen a similar case in a small boy. On being punctured a fluid came out, and the whole thing collapsed. A fortnight later the patient returned to hospital with the growth filled up again. It was removed with forceps, and found to be a cystic fibroma.

Sir FELIX SEMON was of opinion that this was a cystic fibroma. The surface was too granular for a simple cyst.

Dr. KELSON himself thought it was a cystic fibroma. He had cocainised the larynx and felt it with a probe, and it seemed to be rather firm.

CASE OF TUBERCULOUS DISEASE OF LARYNX.

Shown by Dr. W. H. KELSON. This occurred in a woman æt. 42, who came complaining of loss of voice for two months and loss of health for two years. There was swelling and loss of movement of the left arytænoid, and a pink granuloma projecting from the left ventricle and overlapping the left cord. There were indications of phthisis at both apices. A very few bacilli were to be found in the sputa.

Dr. GRANT said it seemed a very pretty case of what was sometimes described as prolapse of the ventricle, which was supposed to be an eversion of the mucous membrane, whereas really it was just a growth of granulation tissue—possibly tubercular—from the ventricle.

CASE OF SYPHILITIC LARYNGITIS, POSSIBLY COMPLICATED WITH TUBERCULOSIS.

Shown by Dr. STCLAIR THOMSON. The patient presented fixation and ulceration of one cord. There was also ulceration of one faucial pillar, and some ulceration on the posterior pharyngeal wall. This assisted in the diagnosis of syphilis, and the condition improved considerably under specific treatment. Still, in spite of large doses of iodide of potassium the condition did not entirely clear up, and, while the cord improved, there seemed to be more infiltration in the inter-arytænoid region. There were no constitutional symptoms of tuberculosis, and the temperature was always subnormal. The man had gained in weight.

Dr. PERMEWAN asked why Dr. Thomson thought this was possibly a case of tubercle. To him it seemed that there were no marked tubercular symptoms, and that it was simply syphilitic.

Dr. STCLAIR THOMSON, in reply, thought the case tubercular because of the intra-arytænoid thickening, which had slightly increased, though the patient had improved with regard to the fixation and ulceration of the cord.

Case of Congenital Absence of the Front of the Nose with Occlusion of the Anterior Nares.

Shown by Mr. Arthur H. Cheatle. The infant was six weeks old. It was the mother's first child, and was born at full time. There was no history of syphilis; the nasal bones were present, but the framework of the nose in front of the nasal bones was absent. The palate was normal, and no other deformities were present.

The President considered this a highly interesting case. Whether it was due to intra-uterine syphilis or not was the only point which might be raised.

The case showed that a person could sleep perfectly quietly when the nose was completely obstructed. Though with polypus of the nose causing partial obstruction there was often great difficulty in breathing and noise during sleep, yet when there was complete obstruction the patient might after a time sleep comfortably.

Dr. FitzGerald Powell said it was a very interesting point whether this was congenital or whether it was due to intra-uterine syphilis, but one would expect to find some other evidence of syphilis in the child if this was a case of intra-uterine syphilis. He should think it would be a case for a plastic operation in later years.

Dr. William Hill asked exactly what was meant by describing the condition of occlusion of the nares as congenital. Did those who employed the term here mean a closure from an inflammatory process occurring during intra-uterine life? Looking at the matter from a purely developmental point of view, the term "congenital" was usually applied rather to a *defect* of closure from arrested development; in this case the nares, formerly patent, had obviously been closed up later by an active inflammatory process *in utero*.

Specimen of Rhinolith.

Shown by Mr. Arthur H. Cheatle. This specimen was removed from a woman æt. about 50 years, who had been troubled with the right side of her nose for twenty years. From the prescription she brought the origin was syphilis. The fœtor was extreme. The rhinolith, which had to be broken before it could be extracted, weighed 140 grains. The nucleus apparently was a portion of necrosed inferior turbinal, as the configuration

of the largest portion of the stone demonstrated. After removal the inferior turbinal was seen to be absent.

Mr. Jackson, of King's College, reported that the stone was composed of calcium phosphate and carbonate in almost equal proportions, together with a trace of organic matter.

A New Form of Laryngeal Forceps.

Shown by Dr. Lambert Lack. These forceps were mentioned at the last meeting. They were similar to Mackenzie's well-known forceps, but the blades formed an *obtuse angle* with the shaft, and thus, when in the larynx, held the epiglottis out of the way. The forceps were also thus removed from the direct line of vision, and enabled a better view of the growth to be obtained at the moment of seizing it; for this reason, also, the blades were much more slender than Mackenzie's. One pair of the forceps were curved forwards at the tip of the blades to enable a growth in the anterior commissure to be more easily reached. The forceps had been used for over three years by various members of the staff at Golden Square, and had been found useful.

Dr. FitzGerald Powell again produced the forceps he had shown at the March meeting, and pointed out how they differed from Dr. Lack's.

A Case of Thyrotomy for Tuberculosis of the Larynx.

Shown by Dr. Lambert Lack. The operation had been performed for what at the time was diagnosed as epithelioma of the larynx, and Dr. Lack thought the case presented many features of interest.

The patient, a finely made, robust man æt. 66, was an old soldier, and, apart from wounds, had never had a day's illness. He was first seen in April, 1901, for hoarseness, which had commenced three months previously and was gradually increasing. On examination an ulcer with raised edges and some surrounding thickening was seen occupying the centre of the

right vocal cord, the movements of which were considerably impaired. The rest of the larynx was of normal colour and contour. The patient had some cough and expectoration, which he stated was not unusual to him during the winter. Examination of the chest showed signs of bronchitis. The sputum was examined for tubercle bacilli with negative result; the patient was otherwise in good health, and no enlarged glands could be felt. The diagnosis pointed so strongly to epithelioma, and the case was so eminently suitable for operation, that thyrotomy was advised and immediately carried out. The entire right vocal cord was removed in the usual way, and the patient's recovery was uninterrupted.

The growth macroscopically looked like an epithelioma, but Dr. Horne, after microscopical examination, reported it as tubercle.

The patient made good progress until the commencement of August, 1901, when enlarged glands were noticed in the neck. In September there was a hard lump under the upper part of the right sterno-mastoid about the size of a walnut, and rather fixed. Immediate removal was advised and at once performed. The operation involved removal of part of the sterno-mastoid muscle, of the spinal accessory nerve, and of the internal jugular vein. Some of the mass of glands, which was removed entire, were found to be breaking down, and looked suspiciously like suppurating tubercular glands. This opinion was confirmed by microscopical examination, and there was no doubt but that this case was really one of tuberculosis throughout. The patient had since remained in his usual state of good health, but had no voice, the cicatricial band which usually takes the place of a removed cord not having formed. The left cord moved freely, but had an apparently hollow space opposite to it. This case seemed a remarkable one for the following reasons:

1. The laryngoscopic appearances of the localised growth on the vocal cord, the normal condition of the rest of the larynx, the patient's age and vigorous health, the absence of signs of tubercle in the chest, the absence of tubercle bacilli in the sputum, etc., all pointed to a diagnosis of epithelioma. (This was confirmed by my colleague, Mr. Parker.)

2. Even after the pathologist's report an error was suspected,

especially when enlarged, hard, fixed glands appeared in the neck.

3. The good result of the operation, although performed for tuberculosis.

4. There were no signs of the presence of phthisis even now.

5. The failure of the formation of the cicatricial band which usually takes the place of the removed cord, and the consequent continuance of aphonia.

Sir FELIX SEMON thought the case very interesting from many points of view. First of all from Dr. Lack's description of the case, *i. e.* from the clinical appearances, there seemed to be hardly any doubt that it was a case of malignant disease. When the microscopic examination disproved that, he could quite understand that Dr. Lack was very much inclined to disbelieve the microscopist in this particular instance.

Then came the glands in the neck, which would help to increase the belief in the malignant nature of the disease. Nevertheless this view was again disproved and the case ultimately shown to be one of tuberculosis.

Thirdly, there was a fact to which Dr. Lack had drawn his particular attention. They knew that usually in cases of thyrotomy undertaken for malignant disease of the larynx, a ridge formed corresponding to where the diseased vocal cord had been removed, and that the voice materially improved, usually up to the end of the first year, but in this case there was a complete absence of such a ridge, and it was impossible to say why.

He was most interested, too, in the appearance of the left vocal cord during phonation. In the latter part of phonation one saw quite distinctly the arytænoid cartilage not merely move inward but make quite a quarter-turn inwards, so that its vocal process pointed directly into the glottis, and the vocal cord assumed a completely triangular form instead of its usual linear outline. He had never seen this before, and, again, it was practically impossible to say why it should be so. It was, of course, due to the action of the lateralis muscle, but why this should contract in this exaggerated way it was difficult to see, unless a sort of subluxation had been produced by all possible energy being put into the action of the remaining vocal cord in the effort to get a better voice.

Dr. PERMEWAN had also noticed this appearance of the left vocal cord with some interest, and it struck him as a sort of rotation or turning on itself which might be due possibly to the fact that the anterior end of the cord might have been cut across. He asked whether the thyrotomy had been only unilateral or whether the excision had extended to this side as well.

Mr. PARKER had seen this case with Dr. Lack from the first, and from the clinical appearances when he first saw the patient he quite agreed with Dr. Lack that there was little doubt as to the malignant

nature of the disease and that the proper treatment was immediate operation.

Dr. Scanes Spicer said this case raised to his mind the question whether resort should not be had in certain cases of tuberculosis of the larynx to the external operation and the removal of the affected area, more especially in those cases in which the tubercular process was definitely localised.

Dr. Jobson Horne said he was the pathologist and microscopist referred to. He had expressed the opinion that the disease was tuberculosis, and not epithelioma, and, as Dr. Lack had stated, he had not departed from that opinion, notwithstanding the surprise the result of the examination had occasioned, for it was not the first time he had microscoped a vocal cord believed to be the seat of epithelioma, and had found tuberculosis. He considered that the statistics had been enriched by Dr. Lack having published this case. It went to show how fallacious and misleading statistics must be which did not include negative cases. To obtain trustworthy statistics of operations for epithelioma of the larynx, Dr. Horne said, there were at least two essentials; the first was to have a microscopic examination made in every case of the parts removed by the operation, and the result of the examination appended; the second, which was, perhaps, more important, was to have the name of the microscopist also stated.

Referring to the suggestion made by Dr. Scanes Spicer, that the result of the case opened up a field for further operations of the kind for tuberculosis of the larynx, Dr. Horne said the results rather disproved than supported the theory. The cord itself presented under the microscope the appearance of chronic, quiescent, and, one might say, arrested tuberculosis. Four months later some glands were removed from the same side of the neck, which doubtless would have been removed at the same time as the thyrotomy was done had they been sufficiently affected. The sections of the glands showed recent and more active tubercle, and suggested a lighting up of old disease with a reinfection, consequent upon the disturbance of the old tuberculous focus in the larynx itself. Dr. Horne expressed himself desirous of showing the sections to the Society at the next meeting.

Mr. W. G. Spencer did not quite agree with the last speaker. He thought this case ought to be classed with those of senile tuberculosis, which had been mentioned by surgeons. They were more common in connection with the bones, but there were other forms of senile tuberculosis occurring in old people, who otherwise had no connection with the disease—no family history—and who had not shown tuberculous lesions in earlier life. All these cases of senile tuberculosis were progressive forms of the disease, and he thought that the operation in this case was amply justifiable, and would contribute to their knowledge of other cases of senile tuberculosis in different positions. As to the frequency of such cases, it might possibly be greater in the larynx, but even here must be very rare. He thought it was of further interest, pathologically, in connection with the question that had been raised of carcinoma of the larynx, *i. e.* whether in old age or towards old age there was a diminished resistance

against the pathological lesion causing epithelioma. Here some chance tubercle bacilli getting on to the patient's cord, and he possibly having less resistance against the attack than in early life, tuberculous disease had developed.

Dr. LACK said the case was such an exceptional one that he did not think it afforded any reasons for operating in other cases of laryngeal tuberculosis. Thyrotomy and even tracheotomy were generally disastrous in these cases. He did not think this could be called an arrested growth, as the hoarseness was of only three months' duration and was increasing. Nor did he think complete excision of a focus of disease likely to spread the infection to the glands.

SPECIMEN OF CYSTIC GROWTH OF THE SEPTUM AND MICROSCOPIC SECTION.

Exhibited by Dr. PEGLER. The tumour was removed from a male patient æt. 30, who came to the hospital January 31st, 1902, complaining of what he thought was a polypus in the nose, creating obstruction. On examination a pendulous body was seen occupying the left middle meatus, bluish grey in colour, and resembling a polypus to all intents and purposes, though less flattened and rather more opaque. A distinct attachment to the left side of the septum was traced by the probe, at about the region of the tubercle or a little higher. Dr. Clayton Fox also examined the case, and an œdematous septal polypoid hypertrophy was diagnosed. It was removed with a Mackenzie snare with the usual antiseptic precautions, and neither bleeding nor serous fluid escaped. The after-appearance of the middle meatus was peculiar, the septum showing a marked indentation, and the anterior half-inch of the middle turbinal being strongly deflected outwards at the site occupied by the growth, which might therefore be presumed to be either of congenital origin or, at all events, to have existed for a long period. It proved on inspection to be a cyst with a short, hollow pedicle. The patient wrote three days later excusing himself from keeping his appointment at the hospital on account of "a bad influenza cold," and did not subsequently return. For full notes of the after-history the exhibitor was indebted to the patient's private medical attendant, who was called in on February 7th. At this time the patient was found to be

suffering from shiverings, pains in the limbs, and headache, with a temperature of 100°. There being three other cases of influenza in the house, this disease was diagnosed. After a temporary improvement the case took an unfavourable turn, and by February 9th symptoms of meningitis had developed. The left arm and leg became paralysed, coma set in, and the eyes were drawn to the left. Later, large twitchings and convulsions invaded the right side of the body, arm, and leg, and the patient died on February 15th. The report states that the initial symptoms indicated right-sided brain trouble, but that the patient had no local signs drawing attention to the nose during the illness, neither swelling, pain, tenderness on pressure, nor discharge, and on this account the exhibitor had not been communicated with. The tumour, which had been placed in spirit immediately after removal for subsequent examination, was handed over to Mr. Bland-Sutton, as there seemed reason, in the light of what had followed, to suspect meningocele. That gentleman had carefully examined it, both macro- and microscopically, but thought "the source of the cyst was a matter for conjecture." The micro-sections showed two distinct zones of tissue; the outer consisted of nasal mucous membrane; it was surrounded by columnar, non-ciliated epithelium, and contained racemose glands, but no sinuses. The inner zone was much thicker in certain situations than others, and was made up of connective tissue containing many elastic fibres, but did not appear to have a definite squamous epithelial lining. The appearances were well shown in the drawing handed round. The specimen had been mounted by Mr. Pollard, of Middlesex Hospital, who also made the micro-sections.

Dr. Dundas Grant thought they all ought to express their indebtedness to Dr. Pegler for bringing forward the case. When a case ended fatally, as this had, the interest was enormously increased, and its instructiveness was increased, perhaps, in geometrical proportion. If Dr. Pegler had only mentioned to them at the outset that the case had terminated fatally, they would have been able to follow his minute description of what seemed rather small details with much greater interest. But he thought the points brought before them showed that the diagnosis he had made as to the site of the tumour was correct, and no doubt he wished to eliminate any possible idea of its being a tumour connected with the meninges, such as a menin-

gocele. The case was a very interesting one, and there was always the possibility of such a coincidence occurring in any one's practice which had to be kept in mind when carrying out even minor operations during a period of epidemics. Many of them had been much distressed by rashes occurring which turned out to be scarlet fever, and the patients suffered considerably, and they themselves were subject to grave anxiety. He thought Dr. Pegler's description should be accepted as correct.

Dr. WINGRAVE said that the evidence of the histology rather showed that whatever central connection the swelling had, it consisted to a great extent of distension of some of the lymph or connective spaces of the periosteum. One could see very clearly the normal mucous membrane covered with what appeared to be the olfactory cells in a somewhat fragmentary state. Underneath that one found a very thick connective-tissue layer with elastic fibres conforming very thoroughly to the description of periosteum. In that deep periosteal layer one would find large distended spaces, so that it was quite possible that it might have been a cystic distension of the periosteal layers, and even possibly that it might have been a continuation of the dura mater. In the absence of a definite statement as to where it was removed from, and in the absence of any histological evidence of meningeal structure, it was a pure assumption to say that it was directly connected with the cranial cavity. Certainly the cyst was not lined with any kind of epithelium suggestive of subdural continuity, or that could be differentiated from the connective-tissue cells themselves.

Dr. HILL suggested that the specimen and sections be referred to the members of the Morbid Growths Committee, who should have power to add other clinicians to their number in order that the questions raised might be thoroughly investigated. The clinical history did suggest very forcibly to many present that this was a case of meningocele. If one removed a polypus from the nose of a patient who soon after died from meningitis, and if it were then found that the presumed polypus was a cyst, and came from the septum of the nose, a strong case was made out in favour of its being a meningocele. Of course, the remarks of both Drs. Pegler and Wingrave went to show that the tumour was not like a meningocele histologically, but then they all knew that congenital abnormalities often underwent alterations in structure. The case was almost unique, and the references in medical literature to the subject were very vague. Whether it turned out that one really had to deal with a genuine cystic tumour of the septum or a meningocele, an important case would have been elucidated and added to their records.

Dr. STCLAIR THOMSON suggested that the possibility of a congenital meningocele should not be dismissed without such a full investigation of the subject as Dr. Hill had proposed.

In investigating the literature of the subject in connection with cerebro-spinal rhinorrhœa, it was suggested by one authority—and it seemed to be a working hypothesis—that some of these cases of spontaneous cerebro-spinal rhinorrhœa might be congenital meningoceles which had spontaneously ruptured. He found amongst the literature that many cases had been put on record of patients who,

sooner or later, became infected through the nose, and a great many of them died with meningeal symptoms.

The importance of the nature of this tumour being definitely settled was so great as to merit the investigation of the Morbid Growths Committee.

The PRESIDENT thought the Society was much indebted to Dr. Pegler for bringing forward this interesting case.

Dr. PEGLER said, in reply, that on receiving the report of subsequent events, his first impression, supposing any connection between the removal of the cyst and the meningitis existed at all, was that the growth had been a meningocele. He had since been led to relinquish that suspicion as a result of the microscopic investigation over which, in addition to Mr. Bland-Sutton, he had the assistance of Dr. Wyatt Wingrave.

The microscopic appearances certainly tallied with his recollection of the attachment of the pedicle. He was anxious that the sections should be referred to the Morbid Growths Committee, but he feared that, there having been no necropsy, a great deal in connection with the case would have to remain conjectural. Anyhow he had brought it forward as a matter of duty, as well as on account of its unique interest, for he had found but little in the literature of septal tumours that had thrown light upon this case. It was stated by unequivocal authorities that cystic growths of the septum and also meningoceles under certain conditions should be excised.

On a show of hands it was unanimously decided to accept Dr. Pegler's offer to refer the specimen and sections to the Morbid Growths Committee.

CASE OF EPIDERMOLYSIS BULLOSA IN A WOMAN, ASSOCIATED WITH MOUTH AND THROAT LESIONS.

Shown by Dr. WILLIAM HILL.

Dr. VINRACE asked Dr. Hill if he proposed to adopt any treatment, and whether he had acquainted himself with any line of treatment which had been acted on in the past in the many hospitals this patient had atttended.

Dr. HILL, in reply to Dr. Vinrace, said that no treatment did any good in these cases as regards the skin lesions.

CASE OF TUMOUR OF THE RIGHT VOCAL CORD FORMED DURING INFLUENZA, IN A MAN ÆT. 50 (FOR DIAGNOSIS).

Shown by Dr. DONELAN. The patient had attended the Italian Hospital two months ago, suffering from influenza. The

paths of infection appeared to have been the pharynx and larynx, as there were well-marked symptoms of true *grippe*. The larynx was intensely congested; there was, however, no growth, and the patient had a clear voice up to the time of attack. Seen again two days ago, a growth about 4 mm. long by 2 mm. wide projected backwards and inwards from about the middle of the right vocal cord. Apart from the hindrance to approximation of the cords due to the growth there appeared to be also some paralysis of the arytænoid muscles.

Dr. StClair Thomson did not altogether follow the description of this case, but there seemed to be some ulceration on the left vocal cord and a good deal of inter-arytænoid thickening. The man had lost weight, the pulse was quick, and he had night sweats. He thought the subject of tuberculosis ought to be borne in mind in connection with this case, for it frequently developed rapidly after influenza.

Dr. Donelan, in reply, said he had seen the patient only at an interval of a month or five weeks, and as the growth had developed only during the last nine weeks he had not had much opportunity of studying the case. The patient had syphilis twenty years ago, which might alter the view taken as to the diagnosis.

Specimen of Fibroma removed from Left Maxillary Antrum of Male æt. 18.

Shown by Dr. FitzGerald Powell. This patient came under observation complaining of nasal obstruction. On examination his septum nasi was seen to be deflected to the left, preventing a good view of the nostril from in front, but on examination of the posterior orifice with a mirror a small growth was observed filling the upper half of the left choanæ; the appearance was that of a polypus or enlarged turbinate. An effort was made to snare it under cocaine, but only a small portion could be removed by the snare. The patient was put under a general anæsthetic, and an attempt made to remove the growth from behind with Howell's adenoid forceps, but in attempting to seize the growth it slipped out of reach, and on pushing the finger in after it a considerable soft mass was felt lying in the left maxillary antrum, through an opening in the posterior third of the inner wall.

Keeping the finger on the growth, a long-handled, sharp spoon was pushed in through the nostril from in front, and using considerable force the growth was freely curetted from its attachment to the under surface of the floor of the orbit and scooped into the nostril, where it was seized by the adenoid forceps pushed up the nostril from in front and drawn out.

It was found to be a dense fibroma about the size of a small kidney. Hæmorrhage was very free during the operation, but stopped when the growth was removed, and the patient was at present doing very well, and had not had a bad symptom since the operation, which was done a week ago.

The PRESIDENT thought it was difficult to extract such a large tumour through the nose so as to be sure of its complete removal.

Dr. POWELL said that nobody was more surprised than he was when the tumour came through the nose entire. When he put his finger into the post-nasal space and felt the mass in the left maxillary antrum, he had no idea that it was of the size it turned out to be. It seemed to have grown from underneath the floor of the orbit. There could not have been a very wide attachment to it, and from the general contour of the tumour he thought that it had come away entirely, though, of course, he was not absolutely certain.

If one had known the size of the tumour it would have been advisable to open the antrum from the front and remove it, or else remove the jaw. But as it came out as it did he was very well satisfied with the result. The case was being kept under inspection to see if there was any recurrence.

CASE OF MALIGNANT GROWTH IN THE NOSE OF A MALE PATIENT ÆT. 61, PROBABLY OF THE NATURE OF ALVEOLAR EPITHELIOMA.

Shown by Dr. DUNDAS GRANT. John C—, æt. 61, presented himself at the Throat and Ear Hospital a week ago on account of complete obstruction of the right nostril and partial obstruction of the left. The right nostril was completely filled with a polypoid growth of a pinkish colour but irregular in shape, and rough over the greater extent of the surface. The irregularities were interspersed with small masses of shiny myxomatous growth. The soft part of the external nose was bulged out-

wards, but there was no displacement of the nasal bones and no bulging of the superior maxilla. There exuded from the nostril a sanious discharge which irritated the margins, and the nose emitted a peculiar heavy smell suggestive of putrefying flesh, and distinct from the odour of ozæna or simple polypus or antral suppuration. Dr. Grant had observed this smell in connection with sarcoma, syphiloma, and epithelioma, and was disposed to think it of some diagnostic value. By posterior rhinoscopy there was seen to be a large mass blocking up the right choana and extending over the back of the left one; it was of the same nature as what was seen in the front, and after palpation showed marks of hæmorrhage. There was no distension of the antrum in any direction, and on transillumination it was found to be perfectly translucent. The trouble dated from the earlier part of last year. In May he spat up some blood which did not appear to come from the lungs; in June and July the back of the throat became somewhat obstructed, and in August a fleshy lump dropped down from the back of the nose into the pharynx, about the size of a small shelled walnut and of a dark colour. During the later months of the year numerous polypi were extracted, but apparently without effecting a complete clearance. In March of this year an endeavour was made to clear the nose through the nasal passages by a surgeon of the highest ability, who considered the growth to be malignant, and although a large quantity was removed, recurrence had taken place by the time he came under Dr. Grant's care.

The case now presented the characters of malignant disease growing from some portion of the nasal cavity, but in all probability not the antrum. There was no enlargement of glands.

A small portion of the growth had been removed and examined microscopically by Dr. Wingrave, who found it to consist of a stroma formed of densely packed fusiform cells and enclosing irregular alveoli which were filled with epithelial cells; the surface epithelium was stratified, the deepest portion consisting of columnar cells covered by nucleated spheroidal cells; this epithelium invaded the stroma, filled the alveoli, and expanded irregularly to become cystic; the cells in the alveoli fell out during preparation. Dr. Wingrave considered that the epithelium had invaded both from the surface and from the glands;

he considered it probably malignant, but the opinion of members was invited as to the nature of the specimen. It might be stated that there was no history of specific infection, and that the patient had of late been gaining flesh, although he had lost it to some degree during the later part of last year.

Dr. Grant suggested an external operation, making an incision round the side of the nose and through the upper lip, to which could be added one below the orbit if excision of the upper jaw, completely or in part, should seem necessary.

Mr. Spencer thought this a very malignant case, and that it was the worst form of burrowing epithelioma or carcinoma of the antrum, and would require removal of the upper jaw. The glands were beginning to enlarge under the jaw which, if taken away at a second operation, might prolong the patient's life a little, but he was afraid the results in these cases were always bad, and hardly any cases with this particular form of growth were cured. Although the section shown was rather thick, yet the chief element was distinctly cylindrical epithelium arranged in alveolar masses, and not sarcoma.

Mr. Robinson thought it doubtful if it was a case of carcinoma at all. In the main it appeared to be sarcomatous with the normal glands embedded in this structure. It certainly was not the usual type of alveolar or glandular carcinoma, such as would arise from the lining membrane of the antrum. Transillumination, which had been done, might here assist, as the antrum appeared to be free. The growth seemed rather to spring from the nasal wall.

Dr. Wingrave said that one of the specimens was somewhat thick, yet clearly showed its epithelial nature, which, he thought, was strongly suggestive of "duct cancer."

Dr. Lack said the section was not a satisfactory one, and hoped the specimen would be referred to the Morbid Growths Committee.

Dr. Dundas Grant expressed his willingness to have the growth submitted to the Morbid Growths Committee, but thought it would be undesirable to postpone the operation on that account.

Case of Paralysis of Left Vocal Cord in a Female æt. 27.

Shown by Dr. Wyatt Wingrave. The patient had complained of hoarseness and shortness of breath for fourteen months, also slight deafness since childhood.

There was a history of two attacks of acute rheumatism.

The voice was weak, and there was dyspnœa and palpitation on the slightest exertion or excitement.

She stated that the voice suddenly changed after a bad cold, and had remained more or less hoarse and weak.

Laryngoscopy showed complete fixation of the left cord in extreme abduction.

There was a double basic systolic murmur, with cardiac dulness extending to supra-sternal notch, associated with thrill and pulsation, although the pupils were equal and radial pulses were equal in volume and synchronous.

The evidence was strongly in favour of an aneurysm involving the left recurrent.

Dr. Permewan said he was rather surprised to hear Dr. Wingrave in his description say that the cord was in extreme abduction. This would be a very unusual condition of things. To him the position of the cord was just the ordinary cadaveric position. He suggested it was a case of recurrent paralysis with a certain amount of swelling of the ventricular band concealing the cord.

Dr. Wingrave mentioned the fact that the left cord was extremely abducted when first seen, being completely hidden by the ventricular band. To-day one could see a little of it, but at the same time he felt that it was somewhat external to the cadaveric position.

A Case of Bulbar Paralysis in a Female æt. 23.

Shown by Dr. Wyatt Wingrave. The patient sought relief for "a lump in the throat and difficult breathing" of fourteen years' duration, but much worse lately.

The voice was weak and articulation imperfect; she spoke indistinctly, as if her mouth were full. She suffered frequently with dyspnœa on the slightest exertion, but worse during sleep. Deglutition was normal. The pupils are equal and react to light and accommodation. The tongue was deeply fissured, red, and slightly tremulous, and its action feeble. There is well-marked facial palsy; knee-jerks are exaggerated.

The larynx showed both cords fixed in a position somewhat mesial to the cadaveric, leaving but a very narrow aperture. Tension was fair, but other movements wanting, with the exception of slight abduction in the right cord. There was a prominent sarcous-looking projection in the posterior commissure, and some slight periarytænoid swelling.

The mother's story was that she had enjoyed fair health, but that fourteen years ago a piece of slate pencil was removed from the right ear under chloroform, which was followed by face paralysis (right side).

She had five healthy brothers and sisters, and neither syphilitic nor tuberculous history could be obtained.

Mr. Tod said that the growth between the cords suggested fixation of the cords rather than paralysis.

The case had been under Mr. Hovell at the London Hospital, and there were some notes to the effect that there had been some disease of the crico-arytænoid joint. This referred to some years back.

Mr. Parker said he had seen this case at the Throat Hospital, Golden Square, some three months back. He then formed the opinion that the facial paralysis was probably traumatic, due to injury by a slate pencil in the ear; at any rate the paralysis was first noticed immediately after its removal under chloroform, when the patient was between seven and eight years old. Shortly after this the voice began to change, which led the mother to seek the advice of the late Sir Morell Mackenzie, since which time the patient had been taken to various laryngologists and various hospitals.

Dr. Lack said that one point of interest about the case was that the patient slept perfectly quietly, although she had dyspnœa when walking about. He did not think she required tracheotomy.

He had seen a case of paralysis and wasting of the arm immediately following the administration of chloroform for a simple operation, and wondered if the history in the case afforded any support to a similar origin.

Dr. Wingrave said that the history of the patient was somewhat involved and unreliable.

She undoubtedly had facial palsy and weakness and tremor of the tongue, but the palate moved perfectly well.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-FOURTH ORDINARY MEETING, *May 2nd*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.), JAMES DONELAN, M.B., } Secretaries.

Present—35 members and 5 visitors.

The minutes of the preceding meeting were read and confirmed.

The following gentleman was unanimously elected as an Ordinary Member of the Society:

Robert Henry Woods, B.A., M.B., B.Ch.Dublin, F.R.C.S.I., 39, Merrion Square East, Dublin.

The following report of the Morbid Growths Committee was read:

On Dr. DUNDAS GRANT'S case of malignant growth in the nose (*vide* 'Proceedings' for April, 1902, p. 108).

The report on this case was postponed for the purpose of examining further sections of the growth.

On Dr. H. PEGLER's case of cystic growth of the septum (*vide* 'Proceedings' for April, 1902, p. 103).

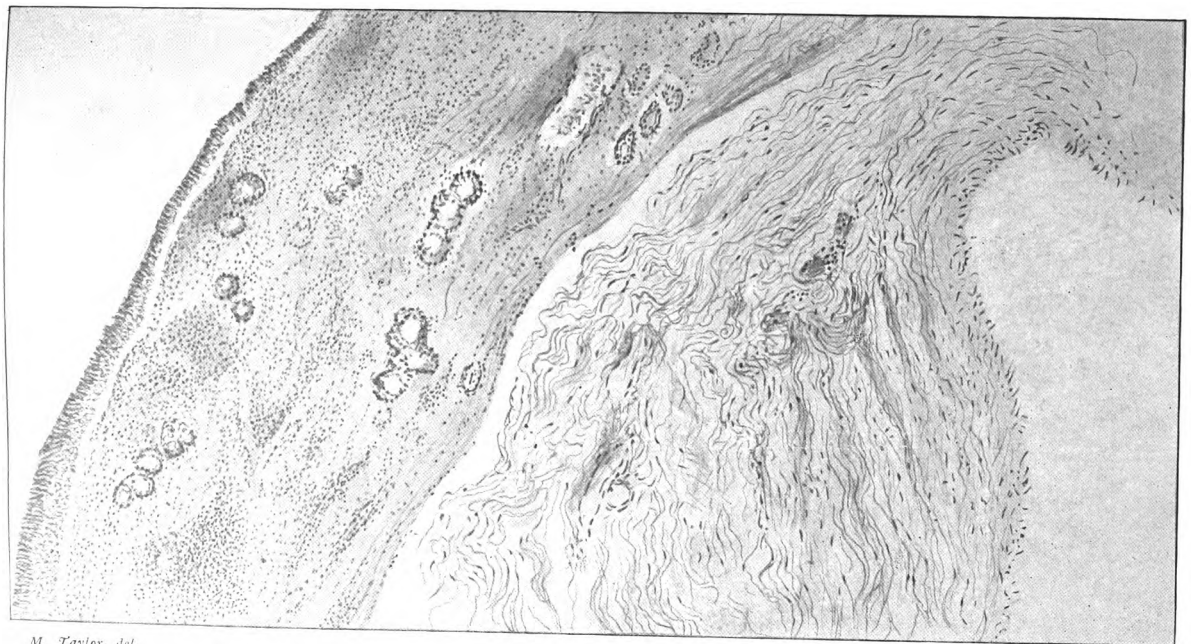
After examination of the specimen and sections submitted, the Committee report as follows:

1. The cyst was evidently of old standing, there being displacement and atrophy of the septum nasi and middle turbinate.
2. The wall of the cyst is composed of the fibrous layer of the periosteum covered with mucous membrane normal to the parts.
3. There is insufficient evidence on which to speak definitely as to the nature of the lining membrane of the cyst. If it was endothelial, no cells now remain.
4. There is no evidence of any embryonic tissue, *e. g.* nævoid.
5. Meningoceles have generally been seen in the middle line, and usually connected with other congenital deformities.
6. The Committee suggest the possibility of a cyst arising in a dilated lymph space of the nasal periosteum, which, perhaps, had a communication with the subarachnoid lymph space.

The following cases, specimens, and sections were shown:

SECTIONS OF A LARGE RECURRENT PAPILLOMA, WHICH SEEMED TO GROW FROM THE LEFT MAXILLARY ANTRUM.

Shown by Dr. BRONNER. The patient, a woman æt. 40, was seen November 14th, 1901. She had had left nasal obstruction for over one year, and for five or six weeks had noticed a purulent and offensive discharge from the left nostril. A large grey mass completely blocked the nostril. This was removed by the snare. There was slight hæmorrhage. A fortnight later there was recurrence. The nostril was scraped, and a large smooth cavity could be felt with the finger, corresponding in position to the antrum, but much larger in size. There had been slight recurrence of the growth, which was removed by the snare. There was now very little discharge, and it was no longer offensive, and there had never been much pain or



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Dr. Pegler's Case of Intra-nasal Cyst (pp. 103—114).

external swelling or hæmorrhage. The symptoms at first seemed to point to epithelioma, but microscopical examination showed the growth to be papilloma. The fact that there had never been much hæmorrhage or pain or external swelling, and that the growth had practically disappeared, also seemed to point to papilloma, from a clinical point of view.

Specimen of Sarcoma of Right Tonsil.

Shown by Dr. Walker Downie. The patient, a woman æt. 58, when first seen on August 17th, 1899, complained of a swelling of the right tonsil, which had been slowly increasing in size since the beginning of that year. It had come on without any apparent cause, and at first gave her only slight discomfort. This discomfort, however, persisted, so she consulted a doctor in March, 1899, who informed her that the tonsil was inflamed and ulcerated. The tonsil was at this time evidently enlarged, and she had some difficulty in swallowing, but there was no marked pain. During the next three months the affected tonsil slowly increased in size, and the patient lost flesh and strength.

In June she consulted another doctor, who proposed to excise the affected tonsil, but on her return two weeks later to have this done the tonsil was found to have increased so much in size in that interval that he had deferred operation, and on August 17th sent the case to Dr. Walker Downie. At this time there was no doubt as to the nature of this new growth. Her temperature was normal. She appeared to be in moderately good health, though complaining of weakness and exhaustion on slight exertion. Her speech was somewhat thick, and she complained of pains shooting up the right side of the throat to the right ear. She could swallow with comparative ease. On examination through the mouth, a tumour occupying the position of the right tonsil was seen, somewhat resembling an hypertrophied tonsil. It was barely the size of an average walnut; it had the form of an enlarged tonsil, and was of a deep red colour, with several greyish patches of superficial erosion distributed over its surface. It was firm to the touch, non-fluctuant, and palpation caused no pain. The faucial pillars

were not adherent to the tumour, which was, as a consequence, freely moveable, and the lymphatics in the neighbourhood were unaffected.

She was admitted to the infirmary with the least possible delay, and on August 23rd the tumour was removed under chloroform. This was effected through the widely opened mouth, and the growth was enucleated by the finger-nail and scissors. Firm pressure over the raw surface checked what bleeding there was. Ice was given frequently for the first few hours after operation, and thereafter small doses of dilute hydrochloric acid were administered several times daily until the parts were healed.

Swelling and ecchymosis of the faucial pillars on the right side followed the operation, but this rapidly subsided, and the patient was dismissed on September 2nd with the parts completely healed.

On microscopic examination the tumour was seen to be a spindle-celled sarcoma. The entire tonsil had been replaced by tumour growth. Towards the surface of the tonsil, however, there was a layer of well-formed connective tissue, covered by the epithelial investment of the tonsil. This latter (not complete in the sections) presented no evidence of invasion by the growth. The tumour, however, in other parts had reached the surface. A spindle-celled sarcoma might, as was known, remain encapsuled for a considerable period, and the glands remain unaffected, and if recognised and enucleated whilst still encapsuled, there was every hope that the operation would effect a cure. Such being the conditions in the present case, this result was hoped for. The patient was not seen again till October, 1901, two years and two months after operation.

On examining the mouth, a small smooth rounded projection about the size of the tip of the little finger was seen springing from the soft palate at a level of the upper border of the right anterior pillar, and close to it. On palpation this projection and the surrounding parts of the palate and fauces were found to be the seat of an infiltration—hard, nodular, and firmly fixed.

Externally there was a fulness just behind the angle of the right lower jaw. On palpation this was found to be hard and

fixed, and to nearly fill the space between the angle of the lower jaw and the tip of the mastoid process.

The woman's health was still fairly good; she was stout and florid, and the local manifestations had increased but slowly, the only additional complaint being that of pain and throbbing in the right ear, aggravated by lying down.

Specimen of a Fibrous Growth removed from the Naso-pharynx of a Boy æt. 14.

Shown by Dr. Walker Downie. The patient, who was first seen on February 21st, 1901, had complete obstruction of the right naris for many months, and latterly the left naris had been similarly affected.

This obstructive difficulty was accompanied by frequent tickling cough, shortness of breath on slight exertion, and disturbed sleep, with loud snoring and suffocative attacks. There were several mucous polypi in the right naris. The naso-pharynx was very completely occupied by a large bluish-grey growth, the lower portion of which, rounded and smooth on the surface, projected below the level of the free border of the soft palate for fully half an inch during respiration, and during deep inspiration a much larger portion of the growth was exposed to view. The movements of the tumour were restricted by the completeness with which it filled the naso-pharynx. This growth was removed by means of a cold wire snare introduced through the mouth. Its removal, though carried out slowly, and by torsion rather than by cutting, was followed by a very profuse hæmorrhage. This was checked by pressure exerted by long strips of lint, packed firmly into the naso-pharynx through the mouth and through both nares.

On microscopic examination the tumour was found to be a richly vascular and very œdematous fibroma, consisting of a dense reticulum of curling fibres, and comparatively few cellular elements.

The operation was followed by continued improvement in the boy's health, and, so far, there had been no recurrence.

Specimen of a Fibrous Growth removed from the Naso-pharynx of a Boy æt. 11.

Shown by Dr. Walker Downie. The patient had had difficulty in breathing through the nose for years, and for at least eighteen months he had snored loudly while asleep; he complained of dry mouth, of occasional frontal headache, and some deafness.

The naso-pharynx, on examination, was found to be completely occupied by a large fleshy growth which bled readily on manipulation.

By digital examination, under chloroform, the growth was found to spring from the vault of the pharynx. Its extirpation was attempted by means of a chain écraseur passed through the nose, but this instrument broke while crushing through the firm fibrous pedicle. It was latterly removed by torsion, while firmly grasped by a curved wire rope écraseur. This was on November 12th, 1892. Twelve months later the left superior maxilla began to swell, and the left naris became obstructed. The left upper jaw, which was then found to be the seat of a sarcoma, was excised, and the result had been subsequent immunity.

Microscopic examination showed this tumour to be a dense fibroma, in which, however, the cellular elements were comparatively numerous.

The tumour was the seat both of hæmorrhage centrally and inflammatory changes along its external aspect.

Specimen of Sarcoma of the Fauces.

Shown by Dr. Walker Downie. The specimen consisted of the soft palate, fauces, pharynx, larynx, and gullet. The patient, a man æt. 33, had been first seen on February 26th, 1901. He then complained of sore throat, pain on deglutition, and huskiness of some three months' duration. On examination the fauces were seen to be in a state of deep congestion, and the left faucial pillars and the greater part of the buccal pharynx

ulcerated. The ulceration, though extensive, was superficial, and was considered to be a late secondary manifestation of syphilis. He was anæmic, emaciated, and feeble, conditions which favour the rapid extension of syphilitic lesions.

Chromic acid solution was applied to the raw surfaces, and mercury with iodide of potassium was prescribed. He improved very greatly up till the end of June, when, without any apparent cause, his cervical glands became enlarged, and he again experienced difficulty in swallowing.

On August 17th, 1901, he was admitted to hospital, and the local lesion was found to have extended very considerably, both in area and in depth. Not only were the left faucial pillars and the buccal pharynx ulcerated, as when first seen, but the whole naso-pharyngeal cavity was raw, and the ulceration had extended down to the opening of the gullet. At the lowest part of the pharynx the mucosa was undermined, and a pocket with gaping mouth was found on the left side, into which food entered, and, to further complicate matters, the posterior wall of the larynx—the arytænoids, and interarytænoid membrane—was greatly swollen. He was, as a consequence, quite unable to swallow any food (in attempting to swallow food it returned through his nose), and a bougie could not be passed into the gullet. It was therefore necessary to resort to rectal feeding, which was maintained till death. The odour of the discharge secreted by and covering the raw surfaces was not only foul, but loathsome.

On admission to hospital his palate had been swollen and inflamed. A few days thereafter liquefaction occurred in the centre of a reddened swollen area to the right of the middle line in the soft palate. The small perforation which resulted steadily increased in size, and at death readily admitted the little finger.

On September 20th he was pale, cachectic, and exhausted, as much from septic absorption as from insufficient food. His pulse was rapid and feeble. In the afternoon he had two attacks of syncope, and early on the following morning he died.

On admission to hospital the cervical glands on the right side formed a swelling considerably larger than a duck's egg, and this swelling slowly increased in size till four days prior to

death, when it very rapidly shrank, and at death was scarcely perceptible.

The man was married. His wife had had no miscarriages, and he was the father of a healthy child of seven months. Up till about twelve months ago he had enjoyed good health, with the exception of frequent attacks of sore throat, which, from his description, appear to have been of the nature of simple acute tonsillitis. He was an iron-turner, of temperate habits, and he denied having contracted any form of venereal disease.

The foregoing lesions were considered to be due to late secondary syphilis. During the earlier course of the illness the ulcers had tended to heal under treatment, and in the later stages the swelling of the palate, which ended in perforation, followed the usual course of a syphilitic infiltration of the palate.

The results of the post-mortem examination were wholly unexpected. The extensive ulceration of the palate, fauces, and pharynx, accompanied by swelling which resembled inflammatory œdema, might well have passed for a syphilitic lesion. But on proceeding further new growths were found in the lungs, the liver, and the kidneys, in all of which the essential features presented were those of round-celled sarcoma.

Case of Laryngeal Stenosis in a Man æt. 50, resulting from a Large Syphilitic Ulcer of Left Side of Larynx.

Shown by Dr. Donelan. Patient was shown at November and January meetings on a question of diagnosis, as there was some suspicion of malignant disease. No decided opinion was given, but the exhibitor was advised to continue the mixed anti-syphilitic treatment under which improvement had taken place. The ulcer was almost healed, but the patient was shown now on account of the stenosis which appeared to be increasing, and in evidence of the fact that even extensive syphilitic disease of the larynx might be successfully treated without any local measures.

Dr. StClair Thomson suggested punching out pieces of the syphilitic infiltration. He had under his care a 'bus driver for four

years whom at times he had threatened with tracheotomy, but on punching out the infiltration of the interarytænoid space and persevering with antisyphilitic treatment, and trying to persuade the patient to drink and smoke less, the man was able to return to his work for a few months.

Case of Syphilitic Contraction of Posterior Pillars of the Fauces in a Man æt. 44.

Shown by Dr. Donelan. This might appear a misdescription without the history. The patient was admitted to the Italian Hospital last September, suffering from pneumonia and a large tertiary ulcer, involving the naso-pharynx, posterior aspect of vomer, and back wall of pharynx. He was in an extremely debilitated state, but, notwithstanding, was given a course of twenty-five inunctions of ʒj of blue ointment, with iodide of sodium internally. The naso-pharynx was regularly sprayed in the first few weeks with perchloride of mercury (1 : 5000), and the patient steadily improved. During his subsequent mixed treatment as an out-patient contraction of the cicatrix gradually took place, and the posterior pillars were gradually drawn together until they are as might be seen now.

Complete Occlusion of Right Nasal Vestibule in a Man æt. 32.

Shown by Dr. Herbert Tilley. The condition followed the insertion of a strong styptic which was applied to check severe bleeding during an attack of pneumonia. The cartilaginous portion of the septum deviated very markedly to the right, and it was thought probable that the occlusion was the result of cicatrisation of the two closely apposed surfaces, the ulceration of which had been induced by the styptic. The exhibitor, at the express desire of the patient, purposed to remove the scar tissue, and at the same time to perform Asch's operation on the septum.

The President said that there was so much deflection of the septum that a cicatrix might easily form across from one side to

the other. There appeared to be no evidence that the case was congenital in character.

Dr. WATSON WILLIAMS thought it was an interesting point that this condition should have followed immediately upon an attack of acute pneumonia. The question of pneumococcal ulceration was so new, and so few cases were known of or described, that it was impossible for him to do more than throw out a suggestion that some of these cases of ulceration might be due to pneumococcal infection.

ADVANCED DESTRUCTION OF INTRA-NASAL STRUCTURES ASSOCIATED WITH SUPPURATION OF THE RIGHT MAXILLARY SINUS.

Shown by Dr. HERBERT TILLEY. The patient, a man æt. 42, had had syphilis six years ago, and the intra-nasal structures had been extensively destroyed. A portion of the vomer alone remained of the septum, and the right middle turbinal was absent. The mucous surface was covered with a thin veneer of dry blood-stained muco-pus. In several features the case resembled that shown by Dr. Bennett at a recent meeting, but in that instance no history of syphilis was present, neither was there any pus in the antra.

The exhibitor wished for the opinion of the Society as to whether such a condition might not arise independently of syphilis, and as a result septic infection of the nasal mucosa.

The PRESIDENT suggested that this might be a case of syphilis; it looked very much like it.

Dr. PEGLER said that Dr. Bennett, who was unable to stay to the discussion, requested him to say that he did not see any parallelism between his case and Dr. Tilley's. In the present one there was not nearly so much perichondrial thickening, nor was there any pain, and in every essential point he thought the two cases quite different.

CASE OF GREAT SYMMETRICAL THICKENING OF THE UPPER AND ANTERIOR PART OF THE NASAL SEPTUM.

Shown by Dr. LAMBERT LACK. The patient, a man æt. 33, had been under treatment for the past twelve years for nasal obstruction. This apparently depended upon a very marked thickening in the neighbourhood of the tubercle of the septum. This

thickening was so great that the case had been diagnosed as a cyst of the septum. It had been cut away and cauterised many times, but had always recurred after a few months or a year. Dr. Lack first saw him about a month ago, and with snare and cutting forceps removed the growth from one side, which is now clear, but the curious growth can still be seen on the other. If this swelling was simply an exaggeration of the boggy thickening of the septum often seen in this region, it was by far the most marked example he had ever met.

Mr. WAGGETT asked if pus, as at the present time, was always to be found in the nose, and whether there was any possibility of this being a case of perichondritis and suppurative disease of the septum itself.

The PRESIDENT asked whether there was any suppurative disease in the left maxillary sinus. He had noticed pus in the left nasal cavity.

Dr. HILL thought that there was some suppuration present, but he imagined that that was not the point which Dr. Lack intended to emphasise in connection with the case; it was rather the recurrence of the large thickening of the septum after it had been freely cut off in large portions with, presumably, a knife. He had had the same difficulties and disappointments himself, and he had almost come to the conclusion that there was a tendency in all soft thickenings of the septum to recurrence after removal, and sometimes even in hard structures also.

Dr. PEGLER had had an almost exactly similar case under his care. He operated two or three times upon the swollen septum and then the patient ceased attending, probably only slightly benefited. He thought these cases were probably syphilitic in origin.

Sir FELIX SEMON suggested that on some future occasion this very important question which had just been raised by Dr. Hill should be made a subject of general discussion. He was glad to hear he was not the only unfortunate person with regard to these cases. It had so often struck him after operations on the septum that the difficulty one had in subduing the subsequent swelling was very great, and literature afforded hardly any assistance as to the after-treatment of these cases.

Dr. LACK regretted that the appearance of this case had completely changed since he last saw it. There was then no pus. The discharge the patient said had commenced during the last week. Dr. Lack was surprised to hear there was often difficulty in preventing recurrence after operations for thickened septum. He had small experience in cases of this kind, but in bony thickenings of the septum he had found no recurrence after operation.

Case of Inherited Syphilis of Nose, Pharynx, and Larynx, with Complete Occlusion of Anterior Nares.

Shown by Dr. Lambert Lack. The patient was a boy who had come under observation three weeks ago with complete occlusion of the left nostril and a red granulating ulcer of the right nostril, with nearly complete atresia of this side also. The soft palate was infiltrated with small nodular patches, and in places there was slight ulceration and scar tissue. The upper part of the larynx was similarly affected, the epiglottis being partially destroyed, and the stump greatly thickened and distorted. Under treatment with potassium iodide internally, and mercury ointment locally, the ulceration of the right nostril had healed, and there was now complete atresia of both anterior nares, with remarkably little sign of loss of tissue or of scarring.

Sir Felix Semon doubted from the appearance of the larynx whether this case was due to syphilis alone, though that disease might in part be the cause. He would think lupus a more probable explanation of the condition, and had no hesitation in saying that the appearance of the epiglottis was almost typical of lupus. Of course, the nose made the diagnosis doubtful, as did the result of the treatment. He thought some tissue ought to be removed and examined for tubercle bacilli. He drew attention to the fact that whilst there was complete occlusion of the nose, there was no deafness.

Dr. Lack would remove a piece for the microscope. He admitted that the condition of the palate and larynx strongly resembled lupus, but considered the favourable result of treatment pointed strongly to syphilis.

Case of Large Laryngeal Growth in a Woman.

Shown by Dr. T. W. Bond. Patient, a married woman, had had some huskiness of voice for thirteen months. She had had no cough, no difficulty or pain in swallowing, no night sweats, and her temperature was normal. There was no history of syphilis. She had had one severe attack of stridor. There were no enlarged glands.

On right side of larynx there was a large red mass, firm to

palpation, extending from below cord to level of tip of epiglottis. The right arytænoid and the ary-epiglottic fold were merged in the mass. The case was shown for the purposes of diagnosis.

Dr. DUNDAS GRANT took the growth to be a sarcoma, and wished to know whether Dr. Bond had also come to this conclusion.

Dr. LACK said some members might remember a somewhat similar case he had shown to the Society in February (see vol. ix, p. 60). This patient had marked œdematous infiltration of one side of the larynx, and especially of the arytænoid, and had been under observation for three months, and taking iodide of potassium without any improvement, and without developing any sign of phthisis. Quite lately, however, tubercle bacilli had appeared in the sputum, and Dr. Lack considered that the large majority of doubtful cases of this kind proved, ultimately, to be tuberculous. He thought this should be the diagnosis of Dr. Bond's case.

Mr. R. LAKE thought there was a difference between this case and the one Dr. Lack had shown them in February last, for the latter was a large smooth growth and not nodular, whereas in this patient the growth was very nodular. He thought the growth here looked as if it had been palpated, and he would like to know whether the redness was due to injury by a finger.

Dr. STCLAIR THOMSON said that this case reminded him of a case he had shown to the Society of a growth in a similar situation in a man about fifteen months ago. The patient was somewhat older than Dr. Bond's patient, being forty-five. It was, when shown, taken by the Society to be a malignant growth, the patient at the time being without any symptoms of tuberculosis. Some two or three weeks after showing him his health broke down, and tubercle bacilli were found. Tracheotomy had to be performed, and the man died of tuberculosis. He thought he had previously mentioned that Dr. Horne had possession of the larynx, which was distinctly tubercular.

Sir FELIX SEMON said that in such cases he thought it was much better not to speak at once of a "tumour" or a "growth," but rather of an "infiltration" or a "swelling," in order not to prejudice one's own diagnosis. Personally, he preferred to call the "growth" in the larynx of this patient an "infiltration." For there was a general infiltration, a little nodular, as Mr. Lake had said, of the right half of the larynx. As soon as one spoke of a "tumour," or a "growth," one's thoughts were immediately directed to the formation of a *new* growth, and left out the other alternative which had been mentioned by Dr. Lack, with whom he agreed in thinking that this would turn out to be tubercular.

Dr. BOND said that, in his opinion, in the *present* condition of the case, he did not think anyone had a right to diagnose it, although one might be permitted to suspect tuberculosis of the larynx. But there were several points against the tubercular supposition; so far as he could learn from the husband, there was no loss of weight, no night sweats, and no cough. When he himself took the temperature for the first time it was normal. To-day, at the end of the examinations,

it was 100°, but as she was at present suckling an infant of four months this rise could easily be explained.

It was a firm feeling growth, but he had not palpated it that day. He did not know whether anyone had done so. He saw the woman six days ago, when there was a red patch on the surface of the tumour. It was open to all to say that it might be a sarcoma, for there was some justification for this opinion. But there were no glands enlarged, and there was a history dating back thirteen months. In such a case one might on operating find the glands enlarged, although they could not be made out as enlarged from a surface examination. He intended to watch the patient, and would be glad to give a further report later on. Probably he would examine a small piece of the growth microscopically.

Glosso-labio-laryngeal Paralysis, with Complete Paralysis of one Vocal Cord and Abductor Paralysis of the other.

Shown by Dr. StClair Thomson. The case was specially interesting, as the progress of the laryngeal paralysis had been watched from an early stage. The patient had complained of thickness of speech for some twelve months. In November last there was only paresis of the abductor muscles. A month ago Dr. Thomson had tried to bring the case before the Society as one of complete double abductor paralysis. Since then the affection had made further progress, for it would be noted that the left cord was completely fixed in the cadaveric position, while the right cord failed entirely in abduction, and on phonation crossed the middle line in its attempt to close with the lifeless left cord. In other words, the only action to be found in the cords was that of adduction in one—the right.

The patient's speech was so thick and indistinct that the poor fellow had been taken up by the police for drunkenness when he was quite sober, and he had great difficulty in earning a living.

Phonation was unimpaired. The vowel sounds were successfully produced, but there was distinct failure of some of the consonants, both labials and dentals. There was conspicuous speech defect owing to failure of co-ordination, yet it was difficult to detect any appreciable paresis of the muscles of the lips; the tongue could be protruded with apparent facility and without tremor, and the soft palate showed no failure in its reflex movements. He could

inflate his cheeks, but could not whistle. There was no dysphagia, but occasional spasm and coughing on drinking. The reflexes and pupils were normal.

The PRESIDENT said an important question in this case was whether or not tracheotomy should be performed, and it would be valuable to have the opinion of members on that point. There was scarcely any interval between the cords. He inquired as to whether there was much anæsthesia of the larynx.

Dr. WATSON WILLIAMS suggested that as the paralysis had developed so rapidly, the probability was that before very long, there being already complete paralysis on one side, there would be complete paralysis on the other side also. The danger of asphyxia would then be greatly lessened. Any operation might only still further complicate the case, and add a new danger.

Dr. STCLAIR THOMSON asked whether tracheotomy was in any way contra-indicated from the existence of anæsthesia of the larynx, which was often present in these cases. Should he be hastening on a fatal termination by doing tracheotomy by reason of the food going down the trachea, which it already showed some signs of doing? The patient was in a rather pitiable state. He was at present able to earn his own living and talk a little, and when it was explained to him that even if operative measures were taken he would be able to talk no better than before, and would probably not be able to continue earning his living, he did not naturally seem inclined to undergo any operation. If anyone had any experience of a case of this sort in which tracheotomy had been performed, he would be very glad to hear of the results.

In reply to the President, Dr. THOMSON said the anæsthesia, though present, was not very marked.

CASE OF EXCRESCENCES OR INCRUSTATIONS OR CHALKY DEPOSITS LOW DOWN IN THE TRACHEA.

Shown by Dr. EDWARD LAW. The patient, a lady æt. 36, came under observation three days ago. She brought a letter from her doctor in South Africa, stating "she has suffered from ozæna, and has, to a great extent, recovered under various methods of treatment. She knows her ailment, and is anxious to get quite well if possible; she has recently lost her sense of smell."

She had first noticed nose trouble as a child with an occasional disagreeable odour from the nostrils. She had employed various nasal solutions with a syringe or douche, but gave those methods

up some years ago on account of the discomfort which they caused at the back of the nose and throat. For some years she had sniffed the nasal solution through the nose. Formerly the voice was very husky and hoarse, but not recently. She now complained of a constant short, hacking cough, loss of smell, indifferent taste, and a slight discharge from the nostrils. There was no history of a foreign body, no dyspnœa nor expectoration, and the general health was satisfactory. An uncle died of cancer of the throat. On examination no atrophic changes were found in the nose, pharynx, or larynx, and nothing abnormal beyond some little catarrhal trouble and a small crust in the neighbourhood of Luschka's tonsil, thus verifying her doctor's statement that she had to a great extent recovered from the ozænic trouble. Low down in the trachea a number of papillomatous excrescences, or crust-like or cretaceous deposits, were seen, a large one with ragged edges on the right side, and a number of smaller ones dotted in an annular or crescentic arrangement around the trachea. There was little or no irritation of the tracheal mucous membrane, but pressure over the windpipe, just above and behind the upper border of the sternum, caused slight pain and discomfort.

The diagnosis was, in Dr. Law's opinion, very uncertain. He had thought of papillomatous excrescences, ozænic incrustations, herpetic crusts, keratosis, ulcer, enchondromata, and chalky deposits.

Dr. Law and the members had to thank Mr. Waggett for his very interesting drawing of the case. Suggestions were solicited in reference to the ætiology, diagnosis, prognosis, and treatment.

Dr. Wm. Hill said that to see this case well a better light was necessary than that afforded, and he suggested that as the paucity of light was so frequent a source of complaint, some steps should be taken with a view to remedying this very serious defect.

Mr. Waggett had had an opportunity of looking at this case for an hour under a very strong light when making the drawing, and he said that with regard to the presence or absence of crusts, a point upon which considerable doubt existed, he was persuaded that there were no crusts, and for the reason that the upper part of the trachea was perfectly healthy in appearance, and in the texture of its mucous lining. On the other hand, those little excrescences had very definite forms; there was the larger mass of a trilobed shape, and there were

about fourteen other little masses which were arranged in an annular manner corresponding to the rings of the trachea; and although the drawing which they had seen might not be absolutely correct, it erred in the omission rather than in the fictitious introduction of masses which were not to be seen with a good light—a strong electric light and a four-inch condenser. He ventured to make a diagnosis that these excrescences were of a papillomatous nature, although he knew opinions on that point differed very widely. There was no true atrophy of the intra-nasal structures. He thought it might be of some interest to add that these little masses did not move during respiration, and that their appearance was absolutely identical now with what it had been twenty-four hours previously.

The PRESIDENT asked Dr. Law whether there was any history of a foreign body having been in the trachea at any time.

Dr. LACK suggested that the growths in the trachea might really be crusts, a view also expressed by other members. The fact that the appearances had not changed in twenty-four hours, in his opinion, in no way militated against this view. They might remain stationary for a week. He suggested that Dr. Law might clear up the diagnosis as to this important point by syringing or spraying the trachea.

Sir FELIX SEMON added his own opinion to the same effect. What induced him to take this view was the co-existence of crusts in the naso-pharynx and (what could not be seen well with the light at their disposal in the adjoining room, but could very well with an oxygen light) the greenish colour of the little protrusions in the trachea, which was quite different from anything with which he was acquainted, either of tracheal excrescences or of a papillomatous nature. As to remaining stationary for twenty-four hours or a week, he would like to mention a little experience of his own. When *in statu pupillari* he observed on a certain occasion an extraordinary (as he thought) excrescence on the right vocal cord of a patient in the Throat Hospital which he could not account for, and so after having it under observation for about a week, he took the patient to Sir Morell Mackenzie, and asked his opinion about this extraordinary growth. Sir Morell Mackenzie, after examining it for a moment, took a dry laryngeal brush, introduced it into the patient's larynx, and having withdrawn it, invited him (the speaker) to look again. He looked, and there was no growth to be seen.

Dr. LAW, in reply to the President, said there was no mention of the presence of a foreign body at any time in the trachea. He would like to suggest that the Council should make some arrangement by which members might be provided with a better light at their meetings for the examination of tracheal cases, for every member who had looked at his case had told him it was almost impossible to do so properly because of the wretched light. With reference to the diagnosis, he was sorry it was still a matter of doubt, as the patient came from South Africa, and was leaving London the following day. He would try and persuade her to return to town for the next meeting. Having carefully examined the condition, he was somewhat opposed to the diagnosis of ozænic crusts. At first the impression made upon him—and he did not at first see the excrescence or deposit

with ragged edges on the right side, but only the somewhat annular arrangement of a number of the projections which were whitish in colour—was that they were a sort of chalky deposits. Afterwards he thought of papillomatous excrescences, of keratosis, of a possible herpetic condition, of ozænic crusts, of an ulcer. But he considered the diagnosis very doubtful. Dr. Thomson had suggested there might be a breach of surface due to an ulcer; he would point out there was some tenderness over the affected part of the trachea.

Case of Removal of Epiglottis for Tuberculous Disease.

Shown by Mr. R. Lake. The patient, a man æt. 30, was sent to him by Dr. Bennett, of Leicester, with the following history :— He was working in a laboratory when the next man, in performing some experiment, produced a very thick cloud of nitrous vapour which irritated the patient's throat. A few days later, as he was suffering with dysphagia, he consulted Dr. Bennett, who diagnosed laryngeal tuberculosis, and found slight crepitations in one apex. He came as an in-patient to Mount Vernon Hospital two weeks later, and after being treated for a week and getting worse, his epiglottis was removed with the galvano-cautery snare. The stump is quite healed and healthy, but the arytænoid regions are still slightly swollen. His lungs now are apparently healthy.

Tuberculous Perichondritis; Case shown at the Society's Meeting, February 7th, 1902.

Shown by Mr. R. Lake. In this case the larynx had been exposed by a large flap incision on March 8th, and on incising the perichondrium a yellowish-white semi-transparent mass was found separating the perichondrium from the cartilage; it was roughly $\frac{3}{16}$ of an inch in thickness. This was carefully removed, and a small spot of disease was found in the mid-line of the cartilage, which was cleared out. Mr. Lake said, had it not been for the advice of his colleague, Mr. F. Spicer, he would have excised the larynx, but he was glad he did not, the man being now in good health and working at his trade, that of a baker. The mass removed was an organised product of inflammation, and was full of giant-cells, with bacilli in most of them.

Case of Geographical Tongue.

Shown by Dr. Pegler. This patient was a boy æt. 4, and he had been subject to "wandering patches" on the tongue since birth. They were more or less circular, and varied in size from a quarter of an inch to an inch in diameter. At present they were fewer and less marked than usual; they often disappear altogether for a few days, and then a fresh set succeeded them. The centre of each patch was red and raw-looking, the edges raised, reddish yellow towards the centre, and white at the periphery. The boy was brought to the hospital for nasal obstruction, which turned out to be due to membranous rhinitis. A quantity of the membrane was removed from the septum in the left fossa under an anæsthetic, with considerable benefit, but traces were still visible.

Case of Syphilitic Necrosis of Intra-nasal Structures, exposing to View the Opening of the Sphenoidal Sinus on each side, and of the Posterior Ethmoidal on the left.

Shown by Mr. Hunter Tod. The patient was an old woman, who came to the London Hospital Out-patients, complaining of headaches and dimness of sight. The nose was filled with crusts, removal of which showed present condition. The eyes were reported by the ophthalmic surgeon to be normal.

Dr. StClair Thomson said that no doubt the openings led into the sphenoidal sinus, but he thought it was quite open to question whether they were the natural ostia sphenoidalia. They appeared to him to be on too low a plane altogether, for the natural openings were more commonly higher up, and it was rare for them to be close against the septum. The natural opening in this case was occluded by granulation and cicatrisation tissue higher up, and the opening now seen was due to the front wall having partly necrosed away.

Dr. Hill said that he had measured the distance of these ostia from the vestibule in this case, which was not more than 2½ inches, and he thought that was one inch anterior to the real sphenoidal openings and lower down. He had seen a similar case in which he had made the mistake of thinking he was dealing with the sphenoidal sinuses when he was not. On measuring he found openings too far forward, and he attributed the abnormality to the formation of

adhesions, but why they should form in this region and simulate the sphenoidal ostia was most curious and inexplicable.

Dr. Watson Williams took the same view of this case as Dr. Hill, and did not think that these were openings into the sphenoidal sinuses. Without measuring it was, of course, difficult to judge distances, but it certainly seemed to him that they were too far forward, and he thought that there was no doubt that the syphilitic changes, which evidently had been very pronounced indeed, occurring in the posterior portion of the nasal passages, would be quite enough to distort the posterior ethmoidal cells and to produce the conditions in this case. Under the existing circumstances it would be very difficult indeed without actual measurement to make up one's mind whether they were ethmoidal cells or sphenoidal sinuses. These openings did not appear to be natural openings, being too large and not situated in the normal situation.

The President regretted he had not seen this case. He did not think there was usually difficulty in recognising the opening into the sphenoidal sinus when it was visible.

Mr. Tod, in reply, said he certainly thought that they were sphenoidal sinus openings, as they were very symmetrical and so central. On the left side they could see above and behind the middle turbinate bone an opening which he took to be the posterior ethmoidal cells. On feeling with a probe between the openings it was quite hard to the touch, but around the openings it was membranous. He was able to pass in a probe on the right side nearly an inch; on the left to a less extent. When the patient first came to hospital he passed a cannula into the openings and pus was washed out, and it came out from each opening separate, showing absence of communication between the two sinuses. He agreed with Dr. Thomson the openings led into the sphenoidal sinuses, although the anterior wall had probably become necrosed and been replaced by membrane.

Cystic Adenoma of Pyramidal Lobe of the Thyroid.

Shown by Mr. Waggett. This occurred in a woman æt. 43, who first noticed a lump in the neck six years ago. A fortnight ago it had become painful, and increased to double its former size. At the present time a firm tumour, the size and shape of a bantam's egg, occupied the subhyoid region of the neck a little to the left of the middle line. Evidently a hæmorrhage had occurred in a cyst.

Dr. Grant considered this a cyst connected with the thyro-lingual duct.

Mr. Waggett said he thought Dr. Grant and himself merely differed on the question of terms. The pyramid lobe of the thyroid gland was the lower part of what was called the thyro-lingual duct.

PROCEEDINGS

OF THE

LARYNGOLOGICAL SOCIETY OF LONDON.

SEVENTY-FIFTH ORDINARY MEETING, *June 6th*, 1902.

E. CRESSWELL BABER, M.B., President, in the Chair.

CHARLES A. PARKER, F.R.C.S.(Ed.), JAMES DONELAN, M.B., } Secretaries.

Present—25 members and 3 visitors.

The minutes of the preceding meeting were read and confirmed.

The PRESIDENT called upon Mr. Charters J. Symonds to open the discussion on

THE DIAGNOSIS AND TREATMENT OF MALIGNANT STRICTURE OF THE ŒSOPHAGUS.

Mr. SYMONDS said—

MR. PRESIDENT AND GENTLEMEN,

To put the subject of this debate briefly, it may be said that the diagnosis of malignant stricture of the œsophagus resolves itself into the passage of a bougie to ascertain the

presence of an obstruction, and the treatment in deciding the best way to introduce food. One sees, however, so many cases treated for dyspepsia that it is necessary to consider a few of the early symptoms. In speaking to an audience of experts, I will limit myself to what appear to me to be essential points, and endeavour not to weary you with unnecessary details.

A gradually increasing dysphagia is the common history in most cases. In by no means a small number the onset is sudden, *e. g.* at a particular meal; a man choked over a mouthful of meat, and from that moment had difficulty. Another, after shouting himself hoarse in welcoming the men from the *Powerful* in the City, had choking the same evening, and developed cricoid obstruction. In one instance a loathing for food, so great as to require feeding by a tube, was the leading sign for some weeks. In another the man complained of pain as the food passed the centre of the gullet.

I have seen one instance where there was no dysphagia; the man was anæmic and was thought to have cancer of the stomach, and when his evacuations were black this view was strengthened. At the autopsy we found the greater portion of the œsophagus occupied by an ulcerating carcinoma, which had enlarged and not constricted the lumen at any point.

Before a bougie is passed a good many patients are treated for dyspepsia, and much valuable time may be lost. One sees such patients losing flesh, not so much on account of inability to swallow, but because the diet has been restricted, on the view that the disease was gastric. It must be remembered that so-called "dyspepsia," *i. e.* loss of appetite, "tightness at the chest," water brush, some pain and distension, with irregular bowels, may be the result of œsophageal obstruction. The restricted diet usually prescribed tends to increase the symptoms. A diagnosis can generally be made by asking the patient to swallow liquid. This when marked is characteristic; he makes one ordinary effort, followed by one or more smaller ones; these are accompanied by certain peculiar movements of the neck. Then he brings up a little gas, often hits his chest, and says now it has gone. Kussmaul's sign, viz. listening to the back to hear the fluid arrested at the stricture and then trickling through, is always interesting, and when the observer does not

pass a bougie is sometimes valuable. I am sure from what I see that an unnecessary fear exists in the minds of many as to the danger attending the use of a bougie. Provided that a fair size be employed, and no force used, and especially that no pressure be made when the patient strains to extrude the instrument, there is no danger. The bougie should be advanced in a deep inspiration or on an act of deglutition, held still on any expulsive effort, and again advanced on inspiration. That there are dangers with fine bougies, and in advanced disease, one cannot deny. In passing the cricoid one must wait for the inspiration which follows the first glottic closure, or make the patient regurgitate by passing the left forefinger far back on the tongue. To press at this moment in close cricoid stricture may send the bougie into the trachea. Once more it may be added that in impermeable cricoid obstruction, where the patient is particularly tolerant, there is special risk of entering the trachea. It is remarkable to note how a patient will bear the presence of a large bougie in the windpipe for some time without coughing. In any doubt we must pass the bougie not more than twelve inches, and examine its position with a laryngoscope. These special points refer rather to treatment; it seemed but right to refer to them here.

With these general remarks, I will next ask you to consider the diagnosis of the disease as it affects the three situations, viz. the upper third and cricoid orifice, the lower end and gastric orifice, and the central region.

1. *Upper third.*—Stricture at the cricoid or beginning just below the ring is, in my experience, always malignant. It begins at 8½ to 9 inches from the teeth, and usually involves 2 or 3 inches. The chief peculiarity is the tendency to cicatrise and contract; so marked is this feature that a specimen may be indistinguishable to the naked eye from a chronic syphilitic or other ulcer. If the margin, however, of such a specimen be examined microscopically, squamous epithelial growth will, I believe, always be found. The contraction is irregular, so that a bougie in passing may have to turn several corners. In the diagnosis of disease at the cricoid I have found three conditions give rise to confusion:

a. The one most closely resembling organic disease is

dysphagia, occurring in elderly people. In the first instance that came under my notice, the patient was a woman æt. 70; there was dysphagia for solids, and fluids caused trouble; a bulb passed with difficulty, there was a streak of blood, and altogether I thought gravely of the case, and gave a serious prognosis. The symptoms soon disappeared, and the patient, after some years, is still well. A similar instance came before me again in a woman over 70, and another in a man over 80. In the persistence, in the indefinite obstruction to a bougie, and in the age of the patient, there is sometimes a close resemblance to malignant disease. There is also an absence of the nervous symptoms seen in younger people. The condition suggests some organic change, giving rise to temporary interference with deglutition. I have thought that possibly an excessive cricoid ossification, or some bony outgrowth interfering with movement, might explain these cases.

b. The nervous form, especially when occurring in men, and in medical men above all others, can only be settled by time. Suddenly such a patient has difficulty at a meal over a mouthful of food, and later cannot swallow a pill or a crust of bread. He has to be more careful in eating than before. It is well known that such is often the history of the early stages of malignant stricture. The passage of a bougie is not easy, a little blood may result to further confuse the issue, or one may fail to pass the bougie beyond the cricoid without undue force. Where such symptoms occur in a man of forty-nine or fifty, the diagnosis is not easy. In both affections the freedom of swallowing varies, in both soft solids are better dealt with. I would say, however, that in malignant disease the patient almost always permits the passage of a bougie, and that there is found irregularity of the surface indicating disease of some standing. Practically in the majority there is no great difficulty, but in a few cases—especially if they happen to be medical friends—it may give rise to no small anxiety. In most cases it is best, I believe, to give a positive opinion as to the simplicity of the case and wait with your own secret fear.

c. The third condition is that of a pharyngeal pouch. When well marked, the symptoms of this complaint are so defined as to quickly clear up any difficulty. The subject has been so well

dealt with before this Society that I need only refer to Mr. Butlin's communications.

Malignant disease of the lower end of the pharynx, involving the arytænoids, cannot be excluded from a discussion upon œsophageal stricture, and as the same treatment is required, I must refer to it here. The main distinctions are the pain accompanying dysphagia; the voice early has the peculiar sound produced by the presence of œdematous arytænoids; again, the growth can usually be seen in the early stages. It appears first as a pale cushion below the arytænoids, and gradually advances, giving rise to early œdema of one or other arytænoid. These patients often continue to swallow fairly well, and can, so far as I have seen, always be relieved by a soft tube. The direct extension to the larynx is the special feature of disease in this situation. Those who have seen many of these cases will have observed the greater frequency in women, and in many at an age nearer thirty than forty. I may add that in one instance—a woman also—the early mass seen below the arytænoid disappeared under iodide of potassium. I have not myself encountered syphilitic disease lower than the pharynx. I have one patient with slight obstruction just above, or at the cricoid, who had originally—some thirty years ago—syphilitic ulceration involving the larynx.

2. *In the middle third* a sarcoma and a myoma may occur, and give rise to obstruction. In one of my cases a sarcoma was found as a localised tumour, but clinically it was indistinguishable from the ordinary carcinoma. With such rare exceptions as these, all obstructions of any moment in this section of the œsophagus are due to carcinoma. It is very noticeable that aneurysm and mediastinal growths rarely give rise to serious dysphagia. Once only have I passed a bougie in a case of aneurysm, and the sensation communicated to the hand was, I thought, diagnostic of the disease. The case was sent to me with a diagnosis that mediastinal pressure was absent. The bougie passed over a convexity and smoothly descended without any difficulty.

Œsophageal pouches occurring in the middle and lower sections are sometimes very difficult to detect. In one patient, æt. 72, symptoms of obstruction had existed for several years; a

bougie was arrested 14 inches from the teeth; on one occasion it slipped past, and there seemed abundance of room. Under chloroform, the largest bougie was several times guided past the orifice. At this time he regurgitated a good third of his food. For another two years he went on much the same, and died somewhat suddenly from another malady. There was no doubt a pouch in this case. The long duration was a strong point against malignant stricture; the second, that he could always take solids.

In another instance a man was sent to me for pyloric vomiting; without going at length into his case, I may say that the symptoms pointed to obstruction low in the gullet, and the large quanity of food retained to the existence of a pouch. He was fed by a tube, and the vomiting ceased. I thought it better that the man should learn to feed himself in this way than undergo a gastrostomy. After a year of such treatment, he is in good health and able to do his work.

3. The *lower end, i. e.* a point 15½ inches to 17 inches from the teeth, is, in my experience, the only locality where we find a simple obstruction. One is justified in saying that, as the obstruction is in this situation, the cause may be simple, and that the mechanical difficulty being overcome, the future carries more hope than does obstruction in any other situation. I have notes of five such cases, two with pathological evidence, while three are clinical. In the first two the symptoms were those of obstruction only, and they died unrelieved. One of the three living cases has had symptoms for some years, and is relieved from time to time by the passage of a coudé bougie; another has swallowed well since a gastrostomy was performed over a year ago, never having required to use the artificial opening; while the third has had symptoms for twenty years, and requires a bougie from time to time. I will again refer to the use of the coudé bougie in obstruction at the lower end; let me here, in referring to diagnosis, insist upon its great value. When a small, straight bougie will not pass, a large coudé may slip through easily. The two specimens referred to showed a simple fibrous thickening, allied, no doubt, to that seen in the pylorus.

Slighter degrees of obstruction occur in this situation, which may be called spasmodic. I have seen only one marked case, a

lady æt. 30, who, when I saw her, had had obstruction for twenty-four hours. A bougie encountered resistance, which yielded as would a tight sphincter. The obstruction was definite, not a purely nervous form. This brings one to the whole question of "spasmodic stricture," so called. Personally I must express a disbelief in such a complaint, apart from the hysterical cases. Of these latter, the two worst occurred, the one in a boy æt. 7, and the other in a man æt. 35, both hospital patients, and both greatly emaciated. The boy was cured by the temptation of a penny currant bun, the man took a pair of the largest bougies. All the cases brought to me for spasm, except the hysterical, have a basis of malignant growth. I have mentioned before that in a growth in any situation there may be, in the early stages, much difficulty from added spasm and varying mechanical alterations in the growth itself, permitting the taking of solids on one day, and of fluids only with difficulty on another.

When the stomach is infiltrated by malignant disease, and so reduced as to hold but a couple of ounces—the so-called leather-bottle stomach—the resemblance to obstruction at the cardiac end of the gullet is very close. In one instance the patient could retain about 1½ ounces, any larger quantity being rejected. But this amount, taken frequently, was retained, and the diagnosis thus established. This was confirmed by operation.

In another, with obstruction at the cardiac orifice, I found, on performing gastrostomy, only a small portion of the stomach free and available for establishing a fistula. I have no doubt that we had entered the stomach through the œsophagus, and that the inability to retain fluid was due to the reduced capacity. After the operation we were never able to introduce more than two ounces at a time.

Of œsophagoscopy I have no personal experience. Its value was recently demonstrated to me by Professor Mickulicz, of Breslau, who showed me a case of actinomycosis recognised by this method. A piece of growth was removed by forceps and examined.

I may summarise the diagnosis in the following way:

1. Among early symptoms we may base so-called "dyspepsia,"

nausea, and repulsion for food; pain alone when the central district is affected.

2. That the passage of a bougie is the only way to clear up the case, and that its employment need not be feared.

3. That extra-œsophageal disease rarely gives rise to serious dysphagia.

4. That spasmodic obstruction, apart from the hysterical form, has always, when decided, an organic cause, and that this would be better called intermittent dysphagia.

5. That with regard to the three special districts it may be said—

a. That all organic obstruction in the upper third is malignant, and has a special tendency to cicatrise.

b. That in the central half of the gullet, a sarcoma or a myoma, both rare diseases, may cause fatal obstruction; that here, also, a pouch may give rise to difficulty in diagnosis, but can generally be excluded.

c. That in the lower end alone does simple stenosis occur, and that here there may be difficulty in distinguishing from cancer of the stomach causing great reduction of the cavity (leather-bottle stomach).

Finally, that in estimating the extent of the disease, the special value of the steel bulb is noted, and also the use of the coudé bougie in obstruction at the lower end.

Treatment.—Speaking generally, it may be said that we can relieve by mechanical means only, and that two methods are available, one to overcome obstruction by inserting a tube of some kind, and the second to open the stomach below the obstruction, *i. e.* perform gastrostomy.

I would put the general question of treatment in the following way, as applying to all cases:

1. While the patient can swallow fluids and semi-solids, and while a bougie can be passed and plenty of nourishment taken, he may be left, so long as—

a. He can swallow well;

b. A small bougie, No. 12 (catheter gauge), can be passed.

2. If the dysphagia increases, even though a bougie can be passed, then a tube must be inserted or gastrostomy performed. These conditions are seen in the soft fungating forms.

3. If a bougie cannot be passed, or goes with difficulty, then the same course must be followed, as we know that complete closure may occur at any time.

4. If both conditions arise, *i. e.* the patient cannot swallow and a bougie cannot be passed, then immediate mechanical treatment is required.

Probably most have summarised their treatment in some such fashion.

I have not advocated the passage of bougies with a view of dilating the stricture. It is injurious in that it irritates and leads to increase of obstruction; it may split a hard stricture and set up rigor and fever from absorption. In my own practice I have abandoned this method in all malignant cases. The object of the small bougie to which I have referred is simply to secure the route so that at any time a tube can be passed for feeding purposes, or the time fixed for gastrostomy. More than this has, in my experience, proved injurious. As applying to all cases, I would here again refer to the advantage of attempting the passage of a tube after a night's rest and a dose of opium.

Turning next to each region, in the upper third we have to note the great tendency to rapid closure and to the certainty of complete obstruction sooner or later. Two methods are available here: (*a*) the long feeding-tube, and (*b*) gastrostomy. Though I have successfully employed a short tube, it does not, as a rule, rest comfortably unless the highest part of the stricture be at least $1\frac{1}{2}$ inches below the cricoid. Of the long tubes, the best is that made from rubber drainage-tube, introduced by the whalebone director. When this cannot be passed, the retention of a silk-web tube for a few days will so enlarge the passage as to enable the other to be inserted, or an ordinary urethral catheter will answer, and sometimes the coudé variety will pass. If the patient be fairly tolerant, the method is a useful one. The tube will last a long time, so much as nine months. If it comes out, it can always be replaced if the attempt be made at once. Should the tube, when rejected, be soft and have lost its elasticity, then a fresh piece must be used. It should never be removed for cleaning, as re-insertion may be difficult. I have conducted many cases to the end with this tube; the main

objection is that saliva cannot as a rule be swallowed, though some patients will sip fluid by the side of the tube.

Another objection is that it does require some dexterity, perhaps, to insert in difficult cases, and much patience, but not more of either than does the passing of a catheter in stricture of the urethra. The form I have for many years used is, as you see, somewhat roughly made, the end of a piece of ordinary No. 10 drainage-tube being sewn up with silk, and a big eye cut above. Note that the end of the introducer is passed into the eye, and a small plug of wool is inserted into the closed end to prevent the introducer slipping through. The proof that the thinnest walled rubber tube would keep a malignant stricture dilated was first pointed out by Mr. Berry. We must contrast this method with gastrostomy, and I would say that where the patient is low and unable to bear abdominal section it is our only plan. As an alternative, I find it has sustained life in comfort equal to the most successful gastrostomy, and greater by far than when the stomach contents escape and cause excoriation. When the patient is intolerant and objects, then we can offer only gastrostomy. The longest time I have known one of these rubber tubes remain unchanged was thirteen months. The obstruction was at the cricoid, and great difficulty was encountered in passing the first long feeding-tube. The rubber form was easily introduced after a few days' residence of the silk-web tube. From time to time small pieces of the rubber tube had to be removed, as it split near the silver cannula. The patient died with the original tube in position. Others have worn it for varying periods. In two cases patients have also worn tracheotomy tubes. One now under treatment has had a rubber tube in eleven months and a tracheal tube four and a half months. The same method answers admirably in disease of the pharynx. In this form the obstruction to a bougie is never very great, and I have had cases fed by a member of the family three or four times a day. Its application is limited. After many trials, I have no doubt that the best tube is the gum-elastic silk-web, with a closed end and two large eyes, and that the best sizes are Nos. 10, 12, and 14; smaller ones are of little use for permanent wear, and dilatation up to 12 is best conducted by the long

tube. The vulcanite pattern introduced by Renvers I have found of no value; it is too hard and too short. The most suitable cases for this method are those where the stricture is short, and has a tendency to contract; then a four-inch tube answers admirably. The position and length of the stricture are ascertained by a steel bulb. As the disease progresses it may be necessary to use a six-inch tube.

In the *central portion, i. e.* for obstruction occurring from a point 10 inches from the teeth to 14½ inches, we can use a short tube in addition to the long one. When introducing this method in 1884* I said I hoped it would give relief in a certain number of cases, and it has fulfilled this forecast and no more.

The experience published in two former papers† represents very well the use and value of the short tube, and later experience has confirmed it. Of recent cases I may cite the following:

A man æt. 55. Dysphagia began early in 1898.

February 24th, 1899.—A short tube was inserted, the stricture, a short and contracting form, being 14 inches from the teeth.

April 21st.—The tube removed at patient's request; great difficulty in inserting another.

May 2nd.—A tube inserted.

July 28th.—A new tube introduced by Mr. Steward.

March 3rd, 1900.—The tube was still in and acting well, *i. e.* over seven months.

Some time later he showed signs of extension to the lung, and died on June 3rd, 1900.

Duration before tubage, twelve months; duration under tubage, sixteen months. Of these certainly thirteen were passed in comfort; and he attended to his business.

In another case the short tube acted perfectly up to the time of death, the treatment covering a period of more than a year.

Disease involving the *lower end* and *cardiac orifice* I have found difficult to treat by tube. I admit that occasionally one has been successful with a short tube or a long one, but as a rule it is rejected on account of the contraction of the diaphragm. Early gastrostomy seems to me the best advice. I advise that this be done while the patient's general condition is

* 'Clin. Soc. Trans.,' vol. xviii.

† 'Brit. Med. Journ.,' April, 1887; 'Lancet,' March and April, 1889.

good. One very strong point in favour of this course is that, as I have said earlier in this paper, simple stenosis may occur in this situation. Given, therefore, a successful gastrostomy, life may be indefinitely prolonged. Moreover it may be possible, especially with the coudé bougie, to dilate the obstruction after the gullet has had a rest. We may at least anticipate some return of swallowing.

Of course, as in other situations, operation would not be undertaken so long as a bougie could be passed and the patient could swallow freely.

Early gastrostomy applies especially to malignant disease in this situation.

I must mention one remarkable case referred to before. A woman with great dysphagia, emaciation, and obstruction at the lower end. A coudé bougie could be passed. As she lived in the country, and as dysphagia was increasing, I performed gastrostomy. From that moment the power to swallow returned, and the second stage of the operation was completed. It has not been necessary to use the stomach opening. The woman remains so well—now more than a year from the operation—that I think the case must have been one of simple obstruction. Dilatation could not have been effected by suturing the stomach to the abdominal wall, and the only other suggestion one can offer is that a tortuosity has been straightened.

In view of the occasional occurrence of simple stenosis at the cardiac orifice, it seems to me our duty to press operation upon our patients when the dysphagia is marked.

The use of chloroform to facilitate the introduction of a tube is a question for discussion. Personally I have always had an objection to it, but I must admit that in cricoid strictures it has been of great service, and deserves a wider employment. So easy is it, however, to pass a small bougie or tube into the trachea, that I make it a rule, after passing a tube for 12 inches, to examine with the laryngoscope to see that it is really in the œsophagus. In one case, when this precaution was omitted, after waiting some time and there being no spasm or cough, milk was poured down and passed into the lung with disastrous consequences.

In another the tube passed through a tracheal fistula.

Reviewing the whole question of treatment and contrasting tubage and gastrostomy, one may say as regards the latter that it at once disposes of all difficulty as regards swallowing; that in obstructions at the cardiac end it should be performed early; that in all patients intolerant of the tube and bougie, time should not be wasted. In advanced cases, where leaking can be prevented and immediate feeding undertaken, the operation may be successful, and there is reason to expect that such a method has been found.

Unfortunately, many cases among the poor are obtained in too advanced a stage for operation to be considered, and there are others who decline operation. It, therefore, is necessary to perfect, as far as possible, the alternative method of tubage. With regard to cricoid strictures and disease in the lower part of the pharynx, I am quite satisfied with the rubber tube, and believe it to be superior to gastrostomy. We want a tube so constructed that it will not easily be regurgitated, and I believe this will be produced. Once a tube has been retained it is never wise to dispense with it, even for a day. I have several times yielded to the patients' wishes in order that they may enjoy the luxury of a solid meal and been unable to re-insert another tube. The insertion of the new tube should immediately follow the withdrawal of the old one, be it a short or a long tube.

The short tube has, as I said, a limited use, being of little service in disease of the two orifices. But in the central section I still find it valuable. It is open to the objection that it is liable to get blocked, and that, again, some skill is required to insert it. With cases where there is no cough I have known it remain unchanged for ten months, and in another three months. There is no necessity to remove these tubes for cleansing purposes; the silk, protected as is now done by fine rubber tubing, will last for months, and the security of the silk is the only anxiety.

When cough arises from extension of growth, or hæmorrhage occurs, the tube will get blocked, and then a long feeding-tube must be used—either a silk-web or a rubber. It is unnecessary on this occasion to go into details, so I will put the question of tubage thus:

The short tube is useful in strictures occurring from a point

10 inches to a point 14 inches from the teeth. It is no use when there is cough on swallowing, indicating perforation. It is of little value when the growth occupies a long stretch of the gullet. It is seldom of use in strictures involving the cardiac orifice, and cannot, as a rule, be borne in disease involving the cricoid level.

In suitable cases it has, however, given good results up to the time when perforation occurs, and then, as a rule, a long feeding-tube answers for the few weeks that remain.

A word must be said as to the dangers of intubation. One has had accidents, fortunately in only one was life much shortened. In one case a tube was passed, under chloroform, through a perforation into the trachea. This showed the danger of chloroform.

In another a soft and ragged œsophagus was perforated, the man being in the last stage of the disease.

In another a tube in the tight cricoid stricture passed into the trachea; the man did not cough, and gave no sign that such an accident had occurred until signs of pneumonia developed.

These accidents occurred some years ago, when one was endeavouring to improve the method of treatment. Since one has systematically used the laryngoscope to ascertain the position of the tube in cricoid strictures, several similar accidents have been avoided. It is essential to use this check when operating under chloroform.

Summary of Treatment.

1. In cricoid obstruction the long rubber tube gives excellent results. When not well borne, gastrostomy, if selected, should be performed early.

2. In disease of the central portion the short tube is serviceable in a fair number of cases, and, when it acts well, is superior to any other method. It must be replaced by the long feeding-tube when pulmonary symptoms arise.

3. In disease of the cardiac orifice tubage is so uncertain that gastrostomy should be performed when dysphagia becomes serious.

Dr. HERBERT TILLEY: I think that most members will agree with me that the term "classical" is one which might well be applied to the address that Mr. Symonds has given us on the subject of the diagnosis and treatment of malignant stricture of the œsophagus. His experience in this class of cases is so unique that anything which others may say on the matter can only be in the nature of accentuating facts which Mr. Symonds has already brought forward. I will not attempt to do more than this. I wish only to bring before the notice of the Society two cases which seem to illustrate the apparent simpleness of some of the symptoms which are so easily overlooked in the early stages of malignant stricture of the œsophagus, and to which Mr. Symonds has referred in the early part of his address.

The first case was seen some four years ago in University College Hospital. A middle-aged man was admitted to a medical ward suffering, or supposed to be suffering, from ulcer of the stomach. The patient had been brought in complaining of acute pain in the stomach, and on three or four occasions he had vomited large quantities of blood. He was very anæmic, and in the absence of any physical signs in the chest or stomach, it was very difficult to say what organic lesion was present. He took food well, and had no difficulty in swallowing; these were puzzling features of the case. I was given an opportunity of examining the patient, and found that although the voice was fairly clear, yet the left vocal cord was paralysed. Of this, there were no symptoms so far as the voice was concerned. On further examination I saw, about three inches down the trachea, a small, pale, nodular mass projecting into the lumen of the trachea. On the strength of this observation I made the diagnosis of malignant disease, probably of one of the mediastinal glands, the enlargement of which had obstructed the trachea. As to whether that gland was a secondary growth no one could say, for the simple reason that there was no evidence of any primary growth in the œsophagus or elsewhere. In the course of a few days the man died from another attack of severe hæmorrhage. At the *post-mortem* examination a malignant ulceration of the lower end of the œsophagus was found, which, as already stated, at no time had caused any obstruction, and the gland I had seen projecting into the trachea was a secondarily infected mediastinal gland. The case is extremely interesting as illustrating (1) how frequently such symptoms may mislead as to the true nature of the case, and (2) the light which may be thrown on an otherwise obscure case by means of a laryngoscopic examination.

The second case was seen about two months ago. The patient, a man aged fifty-one, had lost his voice for two months, and complained of certain stomach symptoms, *e. g.* flatulence, anorexia, inability to swallow solid food, because it immediately induced sickness, etc., and his illness had been attributed to "gouty œsophagitis," whatever that might mean. For some twelve months he had been complaining of a feeling of sickness after taking food. On examining the larynx, I found complete bilateral recurrent paralysis; the patient could only speak in a whisper, and had a very distressing and ineffectual cough. On examination of the chest, no evidence of aneurysm could be found.

Attempts were made to pass œsophageal bougies, but the smallest one could not be passed beyond the level of the lower end of the manubrium sterni. I therefore took this to be a case of malignant disease of the œsophagus. A fortnight later I saw the patient again, and on further examination found above the manubrium sterni and in the region of the left lateral lobe of the thyroid a stony hardness, and many small enlarged cervical glands above the clavicles. The patient died a few days after the consultation, and unfortunately no *post-mortem* was obtainable, and it was therefore impossible to be sure as to the situation of the primary growth, *i. e.* whether it was in the thyroid gland and involved the gullet, or *vice versâ*.

These two cases illustrate the fact that sometimes one may get invaluable information as to the cause of the patient's symptoms by the use of the laryngoscope. In both the cases briefly outlined, the suspicion raised by finding the vocal cords paralysed was the main factor in the formation of a correct diagnosis. My experience has been very much in accordance with that of Mr. Symonds with reference to an apparent œdema of the upper end of the œsophagus, which occurs most commonly in young females suffering from malignant disease of the œsophagus in the neighbourhood of the cricoid cartilage. I remember seeing two young women, one aged twenty-one, the other aged twenty-eight, in which this curious œdema of the upper end of the œsophagus was followed very shortly afterwards by death from malignant disease in the situation referred to.

Sir Felix Semon: I am sorry I was prevented from being present at the beginning of Mr. Symonds' admirable paper, and, therefore, do not know whether he referred to two points, the absence of which rather struck me. In speaking of the differential diagnosis between malignant and other forms of œsophageal obstruction, I heard him say nothing about laryngeal paralysis, nor about the question of the enlargement of the cervical lymphatics. Both these points I have often found to be of considerable importance with regard to the diagnosis of doubtful cases. Dr. Tilley has just quoted a case in which the discovery of a laryngeal paralysis gave the first reliable sign of existence of organic obstruction. I may say that I have seen quite a number of similar cases, and more than once have I found that patients who came to me for laryngeal symptoms, apparently limited to that organ, such as hoarseness and loss of voice, later on developed the ordinary symptoms of malignant disease of the gullet.

In connection with this point, I should like to say that œdema of the neighbouring arytænoid cartilages, if the disease is situated in the cricoid region, is by no means the only laryngeal symptom of œsophageal cancer in that situation. When malignant disease affects the posterior aspect of the cricoid cartilage, it eats its way by no means rarely into the substance of the posterior crico-arytænoid muscles, and causes a true myopathic paralysis of one or both of these muscles. The symptoms resulting from this when the disease affects both sides are stenosis of the glottis and great respiratory difficulty, often enough of greater urgency than the difficulty of swallowing.

I need hardly mention that laryngeal paralysis is by no means limited to cases of cancer of the œsophagus when the latter is situated

in the cricoid region, but that it may also accompany instances of that disease occurring much further down,—that is, one or both recurrent laryngeal nerves are caught in the furrow between the trachea and the œsophagus by a new growth starting from the latter.

With regard to the enlargement of the cervical lymphatic glands, this sign has several times been of considerable value to me, particularly enlargement of those glands which one can feel on pressing hard immediately behind the clavicle when standing behind the patient; but one has to press sometimes very low down to feel these glands enlarged.

With regard to the treatment, I speak with considerable diffidence, for I think we may say we all sit at the feet of Mr. Symonds, who has shown not only this country, but the whole world, how to treat a number of these cases, particularly by the employment of the smaller tubes which he has introduced. In Germany the credit of this is often given to Professor Renvers, although the last-named gentleman himself, when first introducing the method into Germany, acknowledged his indebtedness to Mr. Symonds. Personally I must confess I have not much opportunity of trying the short-tube treatment, and I have been rather unfortunate in those few cases in which I have tried it, for my patients were quite intolerant of the tubes for any length of time, and I had, therefore, to remove them; but in several cases which, later on, I sent to Mr. Symonds considerable relief was given, in two of them for a long time, by the employment of this method.

Should gastrostomy be required, I entirely agree with Mr. Symonds that the operation should not be performed at too late a stage of the disease.

Concerning the introduction of bougies, I have learnt from experience the wisdom of his advice to give in difficult cases the patients a night's rest and a dose of opium previous to the introduction of the tubes. One may succeed by following this simple advice where one has previously failed. Should an anæsthetic be indispensable, the dangers of chloroform in such cases should not be under-rated. I have had a very sad experience of this. About a year ago a lady consulted me on account of difficulty in swallowing. She was thirty-four, and in otherwise excellent state of health, but had lost flesh in consequence of this difficulty. There were no signs of organic disease anywhere in the chest or in the throat, but when I proceeded to introduce a bougie, I did not succeed. The same difficulty was encountered by Mr. Makins, whom the patient had also been advised to consult. He and I agreed that it was desirable to repeat the examination under chloroform. A few days later this was done, the anæsthetic being administered by one of our most experienced and most skilful anæsthetists. When the patient was deeply under the influence of the drug—as in a case of this sort ought to be the case, to exclude all reflex action—I endeavoured to introduce a big bougie, but without success, nor did Mr. Makins have any better fortune. I then tried a smaller one and still failed, and Mr. Makins' attempt met with the same result. The bougie having been withdrawn, the patient showed signs of coming to. The chloroformist said, "Let me give her a whiff more," and proceeded to do so, when the patient died suddenly. Every effort

was made to resuscitate her but all was fruitless. No *post-mortem* examination took place, and to this day I do not really know what was the nature of the disease, but both Mr. Makins and myself concurred in the belief that it was organic.

A propos of the distinction between organic and functional stricture of the œsophagus, I remember having seen two or three quite distinct cases in which, after some initial difficulty, the bougie could be passed quite easily, and in which, after this had been repeated two or three times, the stricture was found to have disappeared. I cannot say that these were not examples of "hysterical" stricture, but then, what is hysterical stricture? Is it not what one would usually call spasmodic? I do not think the existence of such a form of œsophageal stricture can be denied.

In conclusion, I wish to congratulate the Society upon having had so excellent an *exposé* of an important and difficult question as that to which we have just been listening.

Dr. Clifford Beale: I should like to make one small contribution to this debate, and it is in reference to the question of diagnosis by the means of the X rays. The opportunities have not occurred very frequently since more powerful apparatus was introduced, but a good many cases have been examined, and my friend, Dr. Hugh Walsham, handed to me this afternoon four plates which he has made of such cases, two of them being confirmed by a *post-mortem* examination, and these two show certain definite characteristics which may ultimately turn out to be trustworthy in diagnosis, but, of course, with the evidence so slight as it is at present, one can only take things as one finds them. But the important point is this, that in these cases of œsophageal cancer there is a very well-defined shadow thrown on both sides of the normal mediastinal shadow, whereas in the case of enlarged glands at the root of the lungs, the shadow, although something similar in form, is undefined at its edges. As one would expect, a well-defined morbid growth will give a sharp shadow, and a mass of glands with inflammatory thickening round about them will be represented by indefiniteness. [The plates were then shown.] One point with regard to this method of examination by the Röntgen rays is that it gives us more information as to the amount of thickening and growth that may be present. I think we shall all bear out Mr. Symonds when he says that it is the bougie which masks the diagnosis after all; but the bougie only tells us that there is an obstruction and not how extensive the cause of obstruction may be.

As regards the treatment, one cannot help being struck with the fact that cases are recorded (and Mr. Symonds has mentioned one) where, after gastrostomy has been performed, and where, presumably, the patient has been kept quiet for a few days and fed *per rectum*, it is found that the power of swallowing is perfectly restored. In the cases in question that I have heard of—for I have not yet come across one myself—the power of swallowing is apparently as good as ever. Now, when one comes to think of what it is that gastrostomy does for the patient, one finds that it is nothing more than freeing the growth from irritation, and giving it absolute rest. Therefore, this leads one

to think that in the early stages of such a condition one might do a good deal in the same way by keeping the œsophagus as free as possible from irritation, and by giving it rest. I have carried out this idea in the case of a patient who is under treatment now. By getting him to swallow a certain amount of hot water after every meal to wash down the œsophagus, and at the same time giving a small amount of sticky mixture of opium, *i. e.* Liquor Morphiæ combined with glycerine and gum acacia, the result is altogether satisfactory, affording, as far as one is able to judge, both cleanliness and rest. I can also quite confirm what Mr. Symonds says as to the absence of dysphagia in cases where there is pressure from intrathoracic growth and aneurysm. I think the absence of dysphagia may sometimes be a rather striking feature in certain cases of cancer of the œsophagus where the stricture is not complete. As an old Guy's man, I rather expected Mr. Symonds to tell the story that was in vogue there in our student days, of Astley Cooper, who after going through the medical wards at Guy's to see some special cases, had his attention called to an old man, sitting up in bed, whose face, so far as appearances went, was obviously suggestive of cancer. Astley Cooper was told that none of the physicians could find out what was the matter with the old man, and he instantly replied, "Then he must have cancer of the œsophagus; he obviously has cancer, and this form of it is the only one which may give no symptoms."

Cases crop up like this every now and then, which are proved by *post-mortem* examination to have extensive malignant ulceration of the œsophagus, and yet during life, though these patients obviously have cancer somewhere, there is no regurgitation, no difficulty in swallowing, and nothing to call attention to it. I do not know how frequent such cases may be, but still one must always bear in mind the possibility of their occurrence.

Mr. H. B. Robinson: I should like to emphasise a point which was made by Sir Felix Semon, and that is, the great importance of the enlargement of the cervical glands in the diagnosis of malignant stricture of the œsophagus. Its importance struck me forcibly in a case I saw a little time ago. The patient was a man I saw in private practice, who had a mass of enlarged glands just above the right clavicle; he had great pain down the arm, but there was no suspicion whatever of his having any œsophageal disease at all, but when one went into the question and made a few inquiries and passed a bougie, there was undoubted contraction of the œsophagus. His œsophageal symptoms had been of so slight a character that the enlargement of the glands had never been thought to be in any way connected with a growth in the œsophagus.

Another interesting case of œsophageal obstruction which is worth bearing in mind perhaps, although the obstruction was not in the œsophagus itself, but was caused by pressure outside it, was that of a man sent to me with very marked dysphagia. He was about forty-five. The only thing one could see that probably had relation to the dysphagia was the fact that there was some enlargement of the left lobe of the thyroid gland; but still, from what one was able to feel, one did not at the time think it could exert any great pressure on the

œsophagus, though it was the only apparent cause of the difficulty in swallowing. Thinking there might be something deeply placed exerting pressure, I operated and found in the deep part of that gland a cystic adenoma, which was pressing right down between the trachea and the œsophagus and indenting the anterior wall of the œsophagus. I removed it by shelling it out, and the man did perfectly well and has had no further symptoms of dysphagia from that day to this.

Dr. J. Donelan: I should like to ask Mr. Symonds whether he regards as absolute strictures those in the neighbourhood of the stomach, in the lower part of the œsophagus, where it is impossible to pass a tube and keep it in position for any length of time. I remember the very first case I ever saw of this kind as a qualified man was a case which illustrates the point brought forward by Sir Felix Semon, namely, the early occurrence of laryngeal paralysis. It was a case under the care of a distinguished specialist here in London, and laryngeal paralysis had existed for six months. After a time I saw the patient, who said that four days previously he suddenly lost the power of swallowing and had had no food since. I remember I tried to pass several kinds of bougies, but without success, and the only thing I was able to pass was the third string of a violoncello, which is very small, much smaller than any sound. This served afterwards as a guide for the passage of a straight feeding-tube. I kept this in position for some days; the obstruction was sixteen inches from the teeth. The tube I used for this man was a thin one—I don't know now whose name was attached to it—but it was a French tube and very fine; it was much the shape of a Symonds tube, but much thinner. During the six months that the patient lived afterwards it was retained in position. It was taken out on one occasion and there was very great difficulty in putting it back, but ultimately it was replaced and remained in position until the death of the patient. The second introduction was facilitated by the use of cocaine, by passing the tube down as far as possible and then pouring a little cocaine solution through it.

I should like to ask Mr. Symonds whether the similar use of a solution of adrenalin might not be of some use in reducing the turgescence and facilitating the passage of a bougie or tube.

We have lately had some three or four cases examined by means of the Röntgen rays, but in these the lower part of the œsophagus was the seat of disease, and whether in that situation it will be possible to arrive at any more definite conclusion than that already afforded by the passage of a bougie must be a doubtful matter on account of the greater size and number of the intra-thoracic structures that are present. It does not appear to me that the Röntgen rays in this situation can throw more light on the subject than the *bougie*.

Dr. Dundas Grant: I should like to add my tribute of indebtedness to Mr. Symonds for the way in which he has marshalled so many points. I have selected from my memory some of the difficulties which I have experienced.

The following occurred very early in my experience of general practice. The patient was a man of middle age who had increasing

difficulty in swallowing. This difficulty varied a little in its intensity. The man was certainly getting thinner. I had then a consultation with the late Sir Andrew Clarke, who asked me to pass an œsophageal bougie, which I did without any very great difficulty; but he discovered the presence of malignant disease in the abdomen.

In another similar case which I have had more recently under observation, the patient had all the appearances of cancer of the œsophagus. I was unable to pass a bougie through it. Without examining the patient very much further I handed him over to a general surgeon who was anxious to perform gastrostomy. On examining him with a view to that operation he found carcinoma of the liver. In these two cases the contraction of the œsophagus seems to have been reflex in origin; perhaps my experience with regard to these cases has been very exceptional, but I put it forward, and I shall be glad to know whether this is a frequent condition simulating carcinoma of the œsophagus. Again, whether in this second case of mine the administration of chloroform would have helped to clear up the difficulty is an important question, because if it would, I think it is a great argument in favour of administering an anæsthetic in these cases. There was under my care some time ago a patient on whom I failed entirely to pass an œsophageal tube. He was fortunate enough to come into the hands of Mr. Symonds, and I understand that it was under an anæsthetic that he succeeded in introducing a tube, which gave the patient very great comfort for some time. Naturally the objection to chloroform is the risk incurred by its use, and this is a serious factor which has to be reckoned with. I should suppose it was a coincidence in this particular case of Sir Felix Semon's, which had such an unfortunate termination. But whether some involvement of the cardiac nerves makes chloroform more dangerous in cases of œsophageal cancer is a point on which I think there is room for reflection.

In another case I was able to pass a large bougie with perfect facility, and ventured to give the opinion that there was no disease of the œsophagus, but the patient died a few months later, and was reported to me to have been certified as dying from carcinoma of the œsophagus. In another case, which I showed to this Society as one of primary malignant disease of the thyroid gland, there was a general consensus of opinion that it was such. The patient died afterwards at Reading Hospital, and on *post-mortem* examination was found to have extensive disease of the œsophagus certified as carcinoma of the œsophagus, though, indeed, this may have been secondary to the disease of the thyroid gland.

With regard to those cases of spasmodic stricture of the œsophagus, I have seen several cases where a considerable amount of dysphagia has arisen from defective dentition, and I remember well the case of an old gentleman (a medical man) who came to me on account of what he thought to be carcinoma of the œsophagus. On examination, I found that he had lost almost all his teeth, and I recommended him to get some artificial substitutes. Within a few weeks' time after obtaining them there was complete recovery of the power of swallowing.

With regard to the Röntgen rays, I saw a case some little time ago in which a radiograph was taken; the question for decision was whether there was by any chance aneurysm, but there was no pulsation as reported by Dr. Mackenzie Davidson, who made the radiogram. A few weeks afterwards the patient died from a sudden enormous hæmorrhage, and at once the question arose whether this was not after all a mistaken diagnosis, death resulting from rupture of an aneurysm. I do not think it a very rare thing for œsophageal cancer to end fatally from hæmorrhage, but I should be glad to know what is the experience of members with regard to that.

There is one little therapeutic point which I have never had an opportunity of carrying out, but in case it should have its value, I venture to reproduce it for consideration. It was invented by the late Michael, of Hamburg, and is a kind of Hahn's tampon tracheotomy tube, in which the sponge is covered with very thin india-rubber, and some glycerine is introduced between the rubber and the sponge, so that it may dilate and be kept for a long time in the trachea without its getting sodden and soaked with decomposing foods. He states in a paper of his that for a year a patient with a fistula between the upper part of the trachea and the œsophagus was kept alive after the introduction of this tube into the trachea. It remains to be questioned whether in a case of a fairly obvious fistula of this kind it is not a good treatment to do a tracheotomy, and introduce some such dilating tampon cannula.

Mr. President and Gentlemen, I have purposely selected my most unsatisfactory results, and I should be glad to hear how I may avoid them for the future.

The PRESIDENT: Gentlemen, I am sure we are all very much indebted to Mr. Symonds for the able way in which he has brought before us our subject of discussion. His experience of the treatment of these cases of malignant stricture of the œsophagus is, of course, much larger than ours has been. There are one or two points, however, to which I would like to refer. He has mentioned "œsophagoscopy." I do not know, and I should doubt, whether it is of any particular value from the diagnostic point of view, but there is no difficulty in introducing a straight metal tube fitted with a rubber point down to the obstruction. Before using the tube I am in the habit of letting the patient sip some solution of cocaine. Cocaine thus applied also facilitates the introduction of bougies.

In regard to the Röntgen rays, I had a case a short time ago under my care in which a skiagraph was taken, but, unfortunately, the rays did not give any very definite information. The case was confirmed *post mortem* as one of malignant œsophageal stricture.

The dangers of anæsthetics in these cases have been mentioned by Sir Felix Semon and Dr. Dundas Grant; I cannot help thinking that there is some peculiar danger in this class of case from anæsthesia. I remember a case a good many years ago where I was giving chloroform for gastrostomy and the patient very nearly died. Fortunately, we were able to bring him round, but the operation had to be stopped. I think possibly there may be some special liability to

danger in these cases, or the danger may be due to the weak and exhausted state of the patient at the time of operation.

I should like to ask Mr. Symonds if he has any experience of radical treatment in cases of disease of the upper portion of the œsophagus. What are the results of œsophagectomy? Mr. Symonds, in bringing to our notice the subject of cancer of the upper part of the œsophagus, has included the same disease of the lower portion of the pharynx. There was a case under my care recently, a woman æt. 52, who came to the Brighton Throat and Ear Hospital. On depressing the tongue, the top of a growth the size of a walnut could be seen at the lower back part of the pharynx. On examination with the finger, the growth appeared to be pedunculated. Thinking it a suitable case for external excision, I passed her on to Mr. Buck, at the Sussex County Hospital. Under chloroform, laryngotomy was performed and the growth was ligatured round the pedicle and came off easily. It was found to be a squamous-celled epithelioma. Subsequently an external operation was performed on the left side, the pharynx exposed, and the growth excised with scissors, all the disease apparently being removed. The growth was found to extend just to the left arytæno-epiglottidean fold. The patient did perfectly well, and except for a slight attack of bronchitis after the operation there were no complications. The wound healed admirably, but since her discharge from hospital she developed on the right side of the epiglottis a further deposit of epithelioma, which did not spread from the original growth but started as an entirely fresh nodule. The patient declined further operation.

I have not had a large experience of the use of tubes, but I feel more inclined to employ them since hearing Mr. Symonds' very elaborate description of the method of employment. I should have been glad to hear from him a few more particulars about the risks of gastrostomy. Patients always ask what are the risks involved in this operation.

Mr. C. J. Symonds, in his reply, said: I am much obliged for the kind attention the Society has accorded my paper. I have to thank Dr. Tilley and Sir Felix Semon for raising the question of laryngeal paralysis and its value as an early diagnostic sign of œsophageal stricture. On collating my experience for this paper, I found in most of my cases I was able to settle the question of diagnosis in other ways, but I have seen cases, though not similar to those related by Sir Felix Semon, where laryngeal paralysis has helped in diagnosis, and has been the symptom from which the patient has sought relief. I am much interested in the cases referred to by members, and by Mr. Robinson's especially, though certainly I have not come across a case similar to his. Of course, I may have missed them, but I do not, speaking off-hand, recall any case where the enlargement of cervical glands has led me to diagnose malignant stricture of the œsophagus, and I am glad to learn of this case.

The only point of opposition I have had relates to the "spasmodic" type of case. And here let me explain that as I was opening a discussion, I purposely spoke somewhat positively, as I thought it would increase the interest of the debate. The only case I have had which

resembled Sir Felix Semon's was that of a woman who had had obstruction for some hours when I saw her, and it was only on several similar occasions that she experienced it, and in her there was a distinct spasm of the sphincter at the lower end of the œsophagus. I wanted to ask Sir Felix Semon at what part of the œsophagus he found his cause of obstruction. [Sir FELIX SEMON: "Middle."] That I certainly have never found.

With regard to the X rays I have no experience whatever to offer, and I was glad to hear Dr. Beale's answer to my suggestion, which confirms me in my experience that intra-thoracic diseases do not give rise to this trouble.

I would suggest to Dr. Grant, who has asked for any means of assistance which would help him to clear up the difficulties which he has formerly experienced, that he should use the steel bulb. I most certainly would have missed more than one case of malignant disease of the œsophagus if I had not used it. This form* I introduced some years ago for my own convenience more than anything else, and for use in the out-patient room. It answers, I find, very well indeed in diagnosing those soft strictures which will certainly hardly give any signs of their presence to the ordinary conical bougie.

I was glad to hear Dr. Donelan refer to cases of stricture at the lower end of the œsophagus. The position I hold in regard to these cases I put very strongly, because I have been so disappointed with the treatment usually adopted. A long tube such as he described will answer the necessary purpose. Solis Cohn sent me an interesting paper giving a successful case of treatment by short tubes in a stricture at the lower end of the œsophagus, but it is unsatisfactory so far as my experience goes; and so I advise such patients to have gastrostomy done early.

With regard to the President's case of epithelioma, that was not quite what I was referring to. I referred to cases where your only view of the epithelioma is as it creeps up below the arytænoids directly in the middle line. It is so characteristic, being quite different from cases of pharyngeal carcinoma, which begin on one side and creep round in the epiglottic folds. I doubt whether it is worth while excising these growths; they are very unsatisfactory, as they always recur. I think the patient has a better chance if he is left alone. Although I have done these very big operations, one's experience tends to make one put them on one side.

The coudé tubes are passed in the ordinary way; they are most valuable for stricture at the lower end.

As to the question of the danger of gastrostomy which I am asked to answer, I am not prepared to do so at the present time. If performed at an early stage, it should involve very little risk indeed. I have been trying a plan lately, but whether or not it is going to prove sufficiently valuable I do not know yet. My object is to make a better sphincter out of the rectus.

* The elastic stem form with vulcanite bulb at each end was exhibited.

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Archiv für Laryngologie (Berlin).
Revue Hebdomadaire de Laryngologie, etc. (Bordeaux).
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Annales des Maladies de l'Oreille, du Larynx, etc. (Paris).
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The Laryngoscope (St. Louis, U.S.A.).
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